

SERFF Tracking Number: MCHX-126379228 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 44033
 Company Tracking Number: 8034.POL.AR
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.002 Short Term - Unrelated to marketing
 with employer or association groups
 Product Name: 8034.POL.XX Individual Short Term Disability Inco
 Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term
 Disability Income Policy - Time Insurance Company

Filing at a Glance

Company: Time Insurance Company

Product Name: 8034.POL.XX Individual Short Term Disability Inco SERFF Tr Num: MCHX-126379228 State: Arkansas

TOI: H111 Individual Health - Disability Income SERFF Status: Closed-Approved- Closed State Tr Num: 44033

Sub-TOI: H111.002 Short Term - Unrelated to marketing with employer or association groups Co Tr Num: 8034.POL.AR State Status: Approved-Closed

Filing Type: Form/Rate

Author: SPI McHughConsulting

Reviewer(s): Rosalind Minor

Date Submitted: 11/11/2009

Disposition Date: 01/11/2010

Disposition Status: Approved-Closed

Implementation Date Requested: 12/11/2009

Implementation Date:

State Filing Description:

General Information

Project Name: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company Status of Filing in Domicile: Authorized

Project Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company Date Approved in Domicile: 11/03/2009

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 01/11/2010

Explanation for Other Group Market Type:

State Status Changed: 01/11/2010

Deemer Date:

Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting

Corresponding Filing Tracking Number:

Filing Description:

Time Insurance Company

NAIC # 69477 FEIN # 39-0658730

Individual Short Term Disability Policy

SERFF Tracking Number: MCHX-126379228 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 44033
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Disability Income Policy - Time Insurance Company

8034.POL.AR, et al - Policy

See Attached Form Listing

Actuarial Memorandum - Enclosed

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

We are submitting the above captioned forms and rates for your review and approval. The forms are new and not intended to replace any other forms currently in use.

This Short Term Disability program will be marketed to individuals through agent/broker solicitation. This plan will be offered using the applications herewith submitted or as an integrated offer with other plans using previously filed application or enrollment forms. This program has been Filed For Use in the domicile state of Wisconsin effective November 3, 2009.

This program provides short term disability benefits for loss of income of the policyholder when employed on a full-time basis. It also provides for the following optional disability income benefits: not-at-work disability benefits, partial disability benefits, and disability benefits related to pregnancy or childbirth.

Please note that the Policy is numbered using a matrix format, where each section of the document has a unique form number. For example, the Policy face page is numbered 8034.POL.AR while the Exclusions section of the same document is numbered 8034.EXC.AR. The Company employs this form numbered style for administrative and tracking purposes. The Policy will always be issued in their entirety with all sections and form numbers included.

Acceptance of Offer and Attestation form 30054 (10/2009) enclosed herewith is filed for general use purposes and may be used with other insurance products offered by Time Insurance Company, once approved.

These forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Variable data or text is bracketed and a variability statement is enclosed herewith. Variable data will never exclude provisions required by applicable law.

Attached please find any required certifications and/or transmittal forms and filing fees. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

SERFF Tracking Number: MCHX-126379228 State: Arkansas

Filing Company: Time Insurance Company State Tracking Number: 44033

Company Tracking Number: 8034.POL.AR

TOI: H111 Individual Health - Disability Income Sub-TOI: H111.002 Short Term - Unrelated to marketing with employer or association groups

Product Name: 8034.POL.XX Individual Short Term Disability Inco

Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company

Company and Contact

Filing Contact Information

Lauren Regnery, Compliance Assistant mcr@mchughconsulting.com
 McHugh Consulting Resources 215-230-7960 [Phone]
 350 South Main Street, Suite 103 215-230-7961 [FAX]
 Doylestown, PA 18901

Filing Company Information

(This filing was made by a third party - McHughConsulting)

Time Insurance Company CoCode: 69477 State of Domicile: Wisconsin
 501 West Michigan Avenue Group Code: 19 Company Type:
 Milwaukee, WI 53201-0624 Group Name: State ID Number:
 (414) 299-1140 ext. [Phone] FEIN Number: 39-0658730

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|------------------------|---------|----------------|---------------|
| Time Insurance Company | \$50.00 | 11/11/2009 | 31957403 |

SERFF Tracking Number: MCHX-126379228 State: Arkansas

Filing Company: Time Insurance Company State Tracking Number: 44033

Company Tracking Number: 8034.POL.AR

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Product Name: 8034.POL.XX Individual Short Term Disability Inco

Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 01/11/2010 | 01/11/2010 |
| Approved-Closed | Rosalind Minor | 11/19/2009 | 11/19/2009 |

Objection Letters and Response Letters

| Objection Letters | | | | Response Letters | | |
|---------------------------|----------------|------------|----------------|----------------------|------------|----------------|
| Status | Created By | Created On | Date Submitted | Responded By | Created On | Date Submitted |
| Pending Industry Response | Rosalind Minor | 11/16/2009 | 11/16/2009 | SPI McHughConsulting | 11/18/2009 | 11/18/2009 |

Amendments

| Schedule | Schedule Item Name | Created By | Created On | Date Submitted |
|----------|---|----------------------|------------|----------------|
| Form | Short Term Disability Income Policy-Effective Date and Termination Date | SPI McHughConsulting | 01/11/2010 | 01/11/2010 |
| Form | Short Term Disability Income Policy | SPI McHughConsulting | 01/11/2010 | 01/11/2010 |

SERFF Tracking Number: MCHX-126379228 *State:* Arkansas
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Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term
Disability Income Policy - Time Insurance Company

Disposition

Disposition Date: 01/11/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MCHX-126379228 State: Arkansas

Filing Company: Time Insurance Company State Tracking Number: 44033

Company Tracking Number: 8034.POL.AR

TOI: H111 Individual Health - Disability Income Sub-TOI: H111.002 Short Term - Unrelated to marketing with employer or association groups

Product Name: 8034.POL.XX Individual Short Term Disability Inco

Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|-------------------------------|---|----------------------|---------------|
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document (revised) | Health - Actuarial Justification | Approved-Closed | No |
| Supporting Document | Health - Actuarial Justification | Replaced | No |
| Supporting Document | Outline of Coverage | Approved-Closed | Yes |
| Supporting Document | Forms Listing | Approved-Closed | Yes |
| Supporting Document | 11.10.09 Submission Letter | Approved-Closed | Yes |
| Supporting Document | Statement of Variability | Approved-Closed | Yes |
| Supporting Document | Authorization Letter | Approved-Closed | Yes |
| Supporting Document | 11.18.09 Resubmission Letter | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Table of Contents | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Definitions | Approved-Closed | Yes |
| Form (revised) | Short Term Disability Income Policy-Effective Date and Termination Date | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Effective Date and Termination Date | Replaced | Yes |
| Form | Short Term Disability Income Policy-Short Term Disability Income Insurance Benefits | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Exclusions and Limitations | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Claim Provisions | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Premium Provisions | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Recovery Provisions | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Other Provisions | Approved-Closed | Yes |
| Form (revised) | Short Term Disability Income Policy | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy | Replaced | Yes |
| Form | Short Term Disability Income Policy | Replaced | Yes |

| | | | |
|--------------------------|--|------------------------|--|
| SERFF Tracking Number: | MCHX-126379228 | State: | Arkansas |
| Filing Company: | Time Insurance Company | State Tracking Number: | 44033 |
| Company Tracking Number: | 8034.POL.AR | | |
| TOI: | H111 Individual Health - Disability Income | Sub-TOI: | H111.002 Short Term - Unrelated to marketing with employer or association groups |

Product Name: 8034.POL.XX Individual Short Term Disability Inco

Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company

| | | | |
|-----------------------|--|-----------------|-----|
| Form | Short Term Disability Income Insurance | Approved-Closed | Yes |
| | Benefit Schedule | | |
| Form | Acceptance of Offer and Attestation | Approved-Closed | Yes |
| Form | Application Form for Short-Term Disability Insurance | Approved-Closed | Yes |
| Form | Tele-App Part 1 Application | Approved-Closed | Yes |
| Form | Tele-App Part 2 Application | Approved-Closed | Yes |
| Form (revised) | Outline of Coverage | Approved-Closed | Yes |
| Form | Outline of Coverage | Replaced | Yes |

SERFF Tracking Number: MCHX-126379228 *State:* Arkansas
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Disability Income Policy - Time Insurance Company

Disposition

Disposition Date: 11/19/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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| Schedule | Schedule Item | Schedule Item Status | Public Access |
|-------------------------------|---|----------------------|---------------|
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document (revised) | Health - Actuarial Justification | Approved-Closed | No |
| Supporting Document | Health - Actuarial Justification | Replaced | No |
| Supporting Document | Outline of Coverage | Approved-Closed | Yes |
| Supporting Document | Forms Listing | Approved-Closed | Yes |
| Supporting Document | 11.10.09 Submission Letter | Approved-Closed | Yes |
| Supporting Document | Statement of Variability | Approved-Closed | Yes |
| Supporting Document | Authorization Letter | Approved-Closed | Yes |
| Supporting Document | 11.18.09 Resubmission Letter | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Table of Contents | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Definitions | Approved-Closed | Yes |
| Form (revised) | Short Term Disability Income Policy-Effective Date and Termination Date | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Effective Date and Termination Date | Replaced | Yes |
| Form | Short Term Disability Income Policy-Short Term Disability Income Insurance Benefits | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Exclusions and Limitations | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Claim Provisions | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Premium Provisions | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Recovery Provisions | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy-Other Provisions | Approved-Closed | Yes |
| Form (revised) | Short Term Disability Income Policy | Approved-Closed | Yes |
| Form | Short Term Disability Income Policy | Replaced | Yes |
| Form | Short Term Disability Income Policy | Replaced | Yes |

SERFF Tracking Number: MCHX-126379228 State: Arkansas

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| | | | |
|-----------------------|--|-----------------|-----|
| Form | Short Term Disability Income Insurance | Approved-Closed | Yes |
| | Benefit Schedule | | |
| Form | Acceptance of Offer and Attestation | Approved-Closed | Yes |
| Form | Application Form for Short-Term Disability Insurance | Approved-Closed | Yes |
| Form | Tele-App Part 1 Application | Approved-Closed | Yes |
| Form | Tele-App Part 2 Application | Approved-Closed | Yes |
| Form (revised) | Outline of Coverage | Approved-Closed | Yes |
| Form | Outline of Coverage | Replaced | Yes |

SERFF Tracking Number: MCHX-126379228 State: Arkansas
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Disability Income Policy - Time Insurance Company

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 11/16/2009
Submitted Date 11/16/2009
Respond By Date
Dear Lauren Regnery,

This will acknowledge receipt of the captioned filing.

Objection 1

- Short Term Disability Income Policy, 8034.POL.AR (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-79-134.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 11/18/2009
Submitted Date 11/18/2009

Dear Rosalind Minor,

Comments:

Attached is a response to your November 16, 2009 objection letter.

Response 1

Comments: Please see the attached response to your November 16, 2009 objection letter.

Related Objection 1

Applies To:

SERFF Tracking Number: MCHX-126379228 State: Arkansas

Filing Company: Time Insurance Company State Tracking Number: 44033

Company Tracking Number: 8034.POL.AR

TOI: H111 Individual Health - Disability Income Sub-TOI: H111.002 Short Term - Unrelated to marketing with employer or association groups

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Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company

- Short Term Disability Income Policy, 8034.POL.AR (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-79-134.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Health - Actuarial Justification

Comment:

Satisfied -Name: 11.18.09 Resubmission Letter

Comment:

Form Schedule Item Changes

| Form Name | Form Number | Edition Date | Form Type | Action | Action Specific Data | Readability Score | Attach Document |
|-------------------------------------|-------------|--------------|---------------------------------------|---------|----------------------|-------------------|-----------------|
| Short Term Disability Income Policy | 8034.POL.AR | | Policy/Contract/Fraternal Certificate | Revised | | 56.000 | 8034_POL_AR.PDF |
| Previous Version | | | | | | | |
| Short Term Disability Income Policy | 8034.POL.AR | | Policy/Contract/Fraternal Certificate | Initial | | 56.000 | 8034_POL_AR.PDF |
| Outline of Coverage | 8034.OOC.AR | | Outline of Coverage | Revised | | 50.500 | 8034_OOC_AR.PDF |
| Previous Version | | | | | | | |
| Outline of Coverage | 8034.OOC.AR | | Outline of Coverage | Initial | | 50.500 | 8034_OOC_AR.PDF |

No Rate/Rule Schedule items changed.

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Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term
Disability Income Policy - Time Insurance Company

Thank you for your continued assistance with this filing.

Sincerely,
SPI McHughConsulting

SERFF Tracking Number: MCHX-126379228 State: Arkansas

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Company Tracking Number: 8034.POL.AR

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Product Name: 8034.POL.XX Individual Short Term Disability Inco

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Amendment Letter

Submitted Date: 01/11/2010

Comments:

Dear Rosalind Minor,

Thank you very much for taking the time to speak with me today and for reopening this filing. As I mentioned, I am attaching a revised Policy, form number 8034.POL.FL. This is a matrix filing. The only revision is that the Effective Date section now has a state specific form number, 8034.EFF.AR. No other revisions were made to this policy.

Thank you for your continued assistance with this filing.

Sincerely,

Lauren Regnery
Compliance Project Specialist

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

| Form Number | Form Type | Form Name | Action | Form Action Other | Previous Filing # | Replaced Form # | Readability Score | Attachments |
|-----------------|---------------------------------------|---|---------|-------------------|-------------------|-----------------|-------------------|---------------------|
| 8034.EFF.A R | Matrix | Short Term Disability Income Policy-Effective Date and Termination Date | Initial | | | | 56.000 | |
| 8034.POL.A R | Policy/Contract/Fraternal Certificate | Short Term Disability Income Policy | Revised | | | | 56.000 | 8034_POL_A R.PDF |

SERFF Tracking Number: MCHX-126379228 State: Arkansas

Filing Company: Time Insurance Company State Tracking Number: 44033

Company Tracking Number: 8034.POL.AR

TOI: H111 Individual Health - Disability Income Sub-TOI: H111.002 Short Term - Unrelated to marketing with employer or association groups

Product Name: 8034.POL.XX Individual Short Term Disability Inco

Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company

Form Schedule

Lead Form Number: 8034.POL.AR

| Schedule Item | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-------------------------------|-------------|-----------|---|--------|----------------------|-------------|------------|
| Status | | | | | | | |
| Approved-Closed 11/19/2009 | 8034.TOC.XX | Matrix | Short Term Disability Initial Income Policy-Table of Contents | | | 56.000 | |
| Approved-Closed 11/19/2009 | 8034.DEF.AR | Matrix | Short Term Disability Initial Income Policy-Definitions | | | 56.000 | |
| Approved-Closed 01/11/2010 | 8034.EFF.AR | Matrix | Short Term Disability Initial Income Policy-Effective Date and Termination Date | | | 56.000 | |
| Approved-Closed 11/19/2009 | 8034.STD.AR | Matrix | Short Term Disability Initial Income Policy-Short Term Disability Income Insurance Benefits | | | 56.000 | |
| Approved-Closed 11/19/2009 | 8034.EXC.AR | Matrix | Short Term Disability Initial Income Policy-Exclusions and Limitations | | | 56.000 | |
| Approved-Closed 11/19/2009 | 8034.CLM.AR | Matrix | Short Term Disability Initial Income Policy-Claim Provisions | | | 56.000 | |
| Approved-Closed 11/19/2009 | 8034.PRM.AR | Matrix | Short Term Disability Initial Income Policy-Premium Provisions | | | 56.000 | |
| Approved-Closed 11/19/2009 | 8034.REC.XX | Matrix | Short Term Disability Initial Income Policy-Recovery Provisions | | | 56.000 | |
| Approved- | 8034.OTH. | Matrix | Short Term Disability Initial | | | 56.000 | |

SERFF Tracking Number: MCHX-126379228 State: Arkansas

Filing Company: Time Insurance Company State Tracking Number: 44033

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Product Name: 8034.POL.XX Individual Short Term Disability Inco

Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company

| | | | | | | |
|----------------------|-----------|-----------------------|-------------------------------|--------------------|--------|--------------|
| Closed | AR | Income Policy-Other | | | | |
| 11/19/2009 | | Provisions | | | | |
| Approved- | 8034.POL. | Policy/Cont | Short Term Disability Revised | Replaced Form #: | 56.000 | 8034_POL_A |
| Closed | AR | ract/Fratern | Income Policy | Previous Filing #: | | R.PDF |
| 01/11/2010 | | al | | | | |
| | | Certificate | | | | |
| Approved- | 8034.BNS. | Schedule | Short Term Disability Initial | | 52.300 | 8034_BNS_X |
| Closed | XX | Pages | Income Insurance | | | X.PDF |
| 11/19/2009 | | | Benefit Schedule | | | |
| Approved- | Form | Other | Acceptance of Offer Initial | | 62.000 | Form 30054 |
| Closed | 30054 | | and Attestation | | | (10_2009).PD |
| 11/19/2009 (10/2009) | | | | | | F |
| Approved- | Form | Application/ | Application Form for Initial | | 54.000 | Form 30044 |
| Closed | 30044 | Enrollment | Short-Term Disability | | | (10_2009).PD |
| 11/19/2009 (10/2009) | | Form | Insurance | | | F |
| Approved- | Form | Application/ Tele-App | Part 1 Initial | | 54.000 | Form 30064 |
| Closed | 30064 | Enrollment | Application | | | (10_2009).PD |
| 11/19/2009 (10/2009) | | Form | | | | F |
| Approved- | Form | Application/ Tele-App | Part 2 Initial | | 72.000 | Form 30043 |
| Closed | 30043 | Enrollment | Application | | | (10_2009).PD |
| 11/19/2009 (10/2009) | | Form | | | | F |
| Approved- | 8034.OOC. | Outline of | Outline of Coverage Revised | Replaced Form #: | 50.500 | 8034_OOC_A |
| Closed | AR | Coverage | | Previous Filing #: | | R.PDF |
| 11/19/2009 | | | | | | |

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

SHORT TERM DISABILITY INCOME INSURANCE POLICY

The insurance described in this Policy is effective on the date shown in the Benefit Schedule only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan.

This policy describes the benefits and major provisions which affect the Policyholder. The Policy is issued in the State of [Arkansas] and is governed by applicable laws of that State and federal laws, except as otherwise provided by this Policy.

This policy is issued based on the statements and agreements in the application form, any exam that may be required, any other amendments or supplements and the payment of the required premium. This policy and premium cost may be changed. [If that happens, You will be notified of any such changes].

Please read Your policy carefully and become familiar with its terms, limits and conditions.

RIGHT TO EXAMINE POLICY FOR [10-30] DAYS

If You are not satisfied, return the policy to Us or Our agent within [10-30] days after You have received it. All premiums will be refunded and Your coverage will be void.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION FORM FOR INSURANCE

Please read the copy of the application form included with this policy. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the application form. If a material omission or misstatement is made in the application form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount. Carefully check the application form and, if any information shown in the application form is not correct and complete, write to Us at the address above, within [10-30] days.

[insert secretary signature]
Secretary

[insert president signature]
President

[This policy is guaranteed renewable until age [65-75] years.] [This policy contains a Pre-Existing Conditions Limitation.]

NOTICE: This policy insures for loss of income of the Policyholder when employed on a Full-Time Basis. This plan does not pay benefits when income [from Your Primary Occupation] does not exist prior to the date of disability[, except as provided by the Not-At-Work Disability Benefit]. Read Your policy carefully.

GUIDE TO YOUR POLICY

The sections of the policy appear in the following order:

- I. Definitions
- II. Effective Date and Termination Date
- III. Benefits
- IV. Exclusions and Limitations
- V. Claim Provisions
- VI. Premium Provisions
- VII. Recovery Provisions
- VIII. Other Provisions

I. DEFINITIONS

When reading this policy, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this policy are defined below. Just because a term is defined does not mean it is covered. Please read the policy carefully.

Accident or Accidental

Any unexpected event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.
2. It results from a trauma.
3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.
4. It is definite as to time and place.
5. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness or a cerebrovascular accident. Accident does not include any overdose of controlled substance, drug, or narcotic except when taken under the medical advice of a Health Care Practitioner.

Base Wages

The basic gross wage or salary paid as compensation to You for work performed on a Full-Time Basis, but not including overtime pay, bonuses, commissions, or any other special compensation not received as basic wages or salary. [If You are paid on an hourly basis, Base Wages will be based on the hourly rate of pay. No more than [40] hours per week will be considered in determining Base Wages for hourly workers.] Base Wages for self-employed individuals will be calculated by subtracting allowable business deduction amounts from the business's gross income.

Calendar Year

The period beginning on January 1 of any year and ending on December 31 of the same year.

Complications of Pregnancy

Complications of Pregnancy include the following:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, severe preeclampsia and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. Non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Cosmetic Services

A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or relieve or prevent social, emotional or psychological distress.

Effective Date

The date coverage under this plan begins for a Policyholder as stated on the Benefit Schedule. The Policyholder's coverage begins at 12:01 a.m. local time at the Policyholder's state of residence.

Eligible Disability Period

Eligible Disability Period means each separate period of Total [or Partial] Disability. However, a later period of Total [or Partial] Disability will be considered to be a continuation of the earlier "Eligible Disability Period" if it starts while the Policyholder is insured under this coverage and,

1. if the later period of Total [or Partial] Disability is due to the same or related causes as the earlier period of Total [or Partial] Disability, and it is separated by a return to work on a Full-Time Basis for less than [10-360][business days][calendar days], or
2. if the later period of Total [or Partial] Disability is due to causes not related to the earlier period of Total [or Partial] Disability, and it is separated by a return to work on a Full-Time Basis for less than [1-90][business day[s]][calendar day[s]].

The applicable Elimination Period and the Maximum Benefit Period shown on the Benefit Schedule apply to each Eligible Disability Period separately.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90][calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]

Elimination Period

The period of consecutive days that must pass after the beginning of a period of Total [or Partial] Disability before a Policyholder is eligible for specific benefits as shown in the Benefit Schedule under the terms of this plan. No benefits are payable during the Elimination Period. The Elimination Period applies separately to each Maximum Benefit Period.

An Elimination Period will vary depending on if the Total [or Partial] Disability is due to a [Non-Work Related] Sickness or Injury [or pregnancy or childbirth]. The Benefit Schedule will identify the applicable Elimination Periods.

Full-Time Basis

Working or scheduled to work at a job at least [30-40] hours per week for at least [35-50] weeks per Calendar Year for Base Wages.

Health Care Practitioner

A person licensed by the state or other geographic area in which the medical services are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Home Office

Our office in [Milwaukee, Wisconsin] or other administrative offices as indicated by Us.

Immediate Family Member

An Immediate Family Member is:

1. You or Your spouse or
2. The children, brothers, sisters and parents of either You or Your spouse; or
3. The spouses of the children, brothers and sisters of You and Your spouse or
4. Anyone with whom a Policyholder has a relationship based on a legal guardianship.

Injury

Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

Maximum Benefit Period

The maximum time period per Eligible Disability Period for which benefits under this policy are payable following the applicable Elimination Period. [The Maximum Benefit Period is different depending on if the Total [or Partial] Disability is caused by [Non-Work Related Sickness or Injury] [Sickness, Injury,] [or] [pregnancy, or childbirth.] The applicable Maximum Benefit Period is stated on Your Benefit Schedule.

Medically Necessary or Medical Necessity

Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Policyholder's Immediate Family Member. We must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and
2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and
3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and
4. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.

Monthly Benefit

The amount of Monthly Benefit as shown on Your Benefit Schedule.

[Non-Work Related Sickness or Injury

Accidental Injury or Sickness occurring independent of any employment related activity.]

Partial Disability or Partially Disabled

As a result of the [Sickness or Injury][pregnancy or childbirth][Non-Work Related Sickness or Injury] that caused disability and for which You are under the care of a Health Care Practitioner, Your Primary Occupation Base Wages, that were effective on the day prior to Your becoming disabled, are reduced by up to [0-100%], and You are able to:

1. perform one or more, but not all, of the material and substantial duties of Your Primary Occupation on a Full-Time Basis; or
2. perform all of the material and substantial duties of Your Primary Occupation on a part-time basis.

Policyholder

The person to whom the policy is issued as shown in the Benefit Schedule.

Pre-Existing Condition

A Sickness or an Injury and related complications:

1. For which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed during the [6-24]-month period immediately prior to the Policyholder's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
2. That produced signs or symptoms during the [6-24]-month period immediately prior to the Policyholder's Effective Date.

The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

- a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
- b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

[A pregnancy that exists [on the day before][at anytime during the [6-24] month period prior to] the Policyholder's Effective Date will be considered a Pre-Existing Condition.]

Primary Occupation

Your Primary Occupation is the employment activity You engage in on a Full-Time Basis. In the event You are concurrently engaged in a more than one employment activity on a Full-Time Basis, Your Primary Occupation will be considered the employment providing the highest Base Wages.

Recurrent Disability

A period of Total [or Partial] Disability occurring at least [30-90] [calendar][business] days after the termination of a previous period of Total [or Partial] Disability which was a covered Eligible Disability Period under this policy and is not considered a continuation of that prior Eligible Disability Period as defined in this policy.

Sickness

A disease or illness of a Policyholder. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness. Sickness includes Complications of Pregnancy[, but not the pregnancy itself].

Single Plan

A plan of insurance covering only the Policyholder.

[Special Exception Rider

A form that is included with this plan which identifies a body part, system, disease, Sickness, Injury or other condition for a Policyholder in which all charges related to that body part, system, disease, Sickness, Injury or other condition are excluded from coverage for a specified period of time as shown in the Special Exception Rider.]

Total Disability/Totally Disabled

You are unable to perform the essential duties of Your Primary Occupation resulting in [total loss of Base Wages income][a reduction of [50-100]% [or more] of Your Base Wages][, due to disability caused by [Sickness or Injury][Non-Work Related Sickness or Injury][[Sickness, Injury,] or pregnancy or childbirth] for which You are under the care of a Health Care Practitioner]. [Retired individuals and homemakers will not be considered unable to perform an occupation solely because they are unemployed.]

We, Us, Our, Our Company

Time Insurance Company or its administrator.

[Work Related Sickness or Injury

Accidental Injury or Sickness occurring during or arising out of any employment activity.]

You, Your, Yours

The person listed on the Benefit Schedule as the Policyholder.

II. EFFECTIVE DATE AND TERMINATION DATE

Eligibility and Effective Date of Policyholder

A person who is eligible may elect to be covered under this plan by completing and signing an application form and submitting any required premium. [You must be a resident of or employed in Your Primary Occupation in the state where this policy is issued on the Effective Date.]

Evidence of insurability must also be provided. Your coverage will take effect at 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

[This is a Single Plan only.]

[The rates may change for reasons including but not limited to if the Policyholder moves to another zip code or there is a change in benefits or class.]

Termination Date of Coverage

The Policyholder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid in accordance with the laws of the state in which the policy is issued minus any claims that were incurred after the termination date and paid by Us.

This policy will terminate at 12:01 a.m. local time in the state of issue on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this policy or on a later date that is requested by the Policyholder for termination
2. The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
3. The date of death of the Policyholder. In the event of the death of the Policyholder, You will be entitled to a refund of all unearned premiums.
4. [The date there is fraud made by or with the knowledge of any Policyholder filing a claim for benefits.]

[5.] [The date the Policyholder moves to a state where We do not provide insurance coverage.]

[6.] [The date the Policyholder attains age [65-75] years.][The anniversary date of this policy following the Policyholder's [65th – 75th] birthday.]

III. SHORT TERM DISABILITY INCOME INSURANCE BENEFITS

WE WILL PAY BENEFITS ONLY AS PROVIDED IN THIS POLICY, INCLUDING THE BENEFIT SCHEDULE AND ANY RIDERS OR ENDORSEMENTS HERETO. THE MAXIMUM BENEFIT LIMITATION IS SHOWN ON THE BENEFIT SCHEDULE.

REFER TO THE EXCLUSIONS AND LIMITATIONS SECTION OF THE POLICY FOR DISABILITY THAT IS NOT COVERED UNDER THIS POLICY.

We will not pay benefits for disability during a Policyholder's Elimination Period as shown in the Benefit Schedule.

If the Policyholder, while insured under this policy subject to the Effective Date and Termination Date section of this policy, becomes continuously Totally [or Partially] Disabled as a result of [Non-Work Related Sickness or Injury][Injury][.][or] [Sickness] [or pregnancy or childbirth], We will pay Short Term Disability Income Insurance Benefits subject to the provisions below, Exclusions and Limitations provisions and all the terms and conditions of this policy.

Benefits are payable for only one Eligible Disability Period at a time, even if Total [or Partial] Disability is caused by concurrent [Non-Work Related Sickness or Injury] [Sickness or Injury][.][or pregnancy or childbirth]. If You have other short term disability income coverage under another plan with Us or one of Our affiliated companies, We will pay only the plan benefits providing the greatest [total] benefit amount per eligible disability.

Total Disability Benefits

The Monthly Benefit will be paid for an Eligible Disability Period due to the Total Disability from the first day of the Eligible Disability Period following the applicable Elimination Period, as shown on the Benefit Schedule, until the Maximum Benefit Period has been attained or You are no longer Totally Disabled, if earlier. When the Eligible Disability Period occurs during only a portion of a calendar month, the Monthly Benefit due for that period will be prorated according to the days of Total Disability during the Eligible Disability Period occurring that month.

Total Disability Benefits are not payable for any time during the Eligible Disability Period during which You are receiving any wages or compensation for any work, regardless of whether or not it is Your Primary Occupation.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]

[Partial Disability Benefits

A portion of the Monthly Benefit will be paid for an Eligible Disability Period due to Partial Disability from the first day of the Eligible Disability Period following the applicable Elimination Period, as shown on the Benefit Schedule, until the Maximum Benefit Period has been attained. The available benefit would be payable as a percentage of the Monthly Benefit equal to the

percentage of wage loss resulting from the Partial Disability, not to exceed [0-100%] of the Monthly Benefit.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]]

[Disability Benefits Related to Pregnancy or Childbirth

We will pay benefits under this policy for Total [or Partial] Disability that is related to or caused by pregnancy or childbirth, including complications, only when such Disability commences after the first [10-24] months from the Effective Date. Benefits are limited by the Maximum Benefit Period specifically for pregnancy or childbirth as stated on the Benefit Schedule.] [A condition that has been specifically excluded from coverage will continue to be excluded after [10-24] months of continuous coverage.]]

[Waiver of Premium

[This Waiver of Premium provision becomes effective only after You have been continuously insured under this policy for [[15-365] days][[2-18] months]. [After such waiting period, i][l]n the event You are continuously Totally [or Partially] Disabled for at least 90 calendar days, We will waive [monthly] premium payments due for the remainder of the current Eligible Disability Period up to the Maximum Benefit Period. When Waiver of Premium benefit is being provided, You are required to provide a monthly Health Care Practitioner's statement documenting Your continued Total [or Partial] Disability. Under no circumstances will Waiver of Premium extend beyond the period during which You are Totally [or Partially] Disabled. [We will not waive premium for any disability related to pregnancy or childbirth regardless of the duration of the disability.] [The Waiver of Premium benefit is only available during the course of one Eligible Disability Period every [3-5] years.]]

IV. EXCLUSIONS AND LIMITATIONS

[Pre-Existing Conditions Limitation

We will not pay benefits under this policy for Total [or Partial] Disability that is related to or caused by a Pre-Existing Condition until the Policyholder has been continuously covered under this policy for [12-24] months. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.] [A pregnancy that exists [on the day before][at any time during the [6-24]month period prior to] the Policyholder's Effective Date will be considered a Pre-Existing Condition.]]

[Sickness Limitation on New Policy

We will not pay benefits under this policy for Total [or Partial] Disability that is related to or caused by a Sickness that manifests itself or is diagnosed or treated within the first 30 days from the Effective Date until the Policyholder has been continuously covered under this policy for [12-24] months. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.]]

General Exclusions

We will not pay benefits for Total Disability [or Partial Disability] caused, whether in whole or in part, by any of the following:

1. disability for which Our liability cannot be determined because a Policyholder, Health Care Practitioner, facility, or other individual or entity within 30 calendar days of Our request, failed to:
 - a. Authorize the release of all medical records to Us and other information We requested.
 - b. Provide Us with information We requested about pending claims or other insurance coverage.
 - c. Provide Us with information as required by any contract with Us.
 - d. Provide Us with information that is accurate and complete.
 - e. Have any examination completed as We requested.
 - f. Provide reasonable cooperation to any requests made by Us

Upon receipt of information allowing the determination of Our liability, We will reopen any claim for benefits. No claim for benefits can be reopened after [180-540] [calendar][business] days.

- [2.] [disability that is related to or a complication of a Pre-Existing Condition.]
- [3.] [disability caused by [Work-Related] Sickness or Injury[eligible for benefits under worker's compensation, employers' liability or similar laws even when the Policyholder does not file a claim for benefits]. [This exclusion will not apply to any of the following:
 - [a.] [The sole proprietor, if the Policyholder's employer is a proprietorship.]
 - [b.] [A partner of the Policyholder's employer, if the employer is a partnership.]

- [c.] [An executive officer of the Policyholder's employer, if the Policyholder's employer is a corporation.]
 - [d.] [A Policyholder who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.]]]
- [4.] [disability for which a Policyholder is entitled to loss of income benefits under any motor vehicle medical payment or premises medical expense coverage. Coverage under this policy is secondary to disability income payment or coverage available to the Policyholder, regardless of whether such other coverage is described as secondary, excess or contingent.]
- [5.] [disability caused by or contributed to by:
- a. War or any act of war, whether declared or undeclared.
 - b. Participation in the military service of any country or international organization, including non-military units supporting such forces.
 - c. Foreign or domestic acts of terrorism[that result in a nationwide epidemic].]
- [6.] [disability caused by or related to the Policyholder's weight or related to obesity or morbid obesity conditions, including treatment thereof.]
- [7.] [disability caused by or related to maternity, pregnancy, or childbirth[when the disability begins less than [270-365] calendar days from the Effective Date or date of reinstatement], except for Complications of Pregnancy.]
- [8.] [disability caused by or related to the following, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual function, and treatments thereof.]
- [9.] [disability caused by or related to treatment, services, supplies or drugs designed or used to diagnose, treat, alter, impact, or differentiate a Policyholder's genetic make-up or genetic predisposition.]
- [10.] [disability caused by or related to: [mental illness; anxiety or nervous disorders;] [being intoxicated or under the influence of any controlled substance, except when taken under the medical advice of a Health Care Practitioner;] [behavior modification or behavioral (conduct) problems;] or [learning disabilities]. [Mental illness and anxiety or nervous disorders include all disorders listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.]]
- [11.] [disability caused by or related to an Injury sustained in operating a motor vehicle while the Policyholder is intoxicated and, as defined by law, the Policyholder's blood alcohol level was over the legal limit. This exclusion applies whether or not the Policyholder is charged with any violation in connection with the Accident.]

- [12.] [disability caused by or related to Sickness or Injury of which a contributing cause was the Policyholder's voluntary attempt to commit, participation in or commission of a felony, misdemeanor, or illegal act.]
- [13.] any amount in excess of the Maximum Benefit Period or any other maximum benefit for covered benefits.
- [14.] disability caused by or related to Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, including voluntary ingestion, inhalation or injection of poisons, toxins or gaseous substances, even if the Policyholder did not intend to cause the harm which resulted from the action. This exclusion applies regardless of whether the Policyholder was sane or insane at the time the event occurred.
- [15.] [disability caused by or related to Injury received while engaging in any hazardous occupation or other activity including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [horse riding] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]
- [16.] [disability caused by or related to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [skiing], [horse riding] [, hunting] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]
- [17.] disability caused by or related to chemical peels, reconstructive or cosmetic/plastic surgery that does not alleviate a functional impairment, and other Cosmetic Services.
- [18.] [disability occurring or being treated outside of the United States [or Canada].]
- [19.] disability caused by or related to flight in an aircraft other than as a fare-paying passenger on a regularly scheduled flight by an airline.
- [20.] disability caused by or related to any organ donation[, within the first 12 months following the Effective Date], sterilization or any other [elective] procedure that is not Medically Necessary.

[21.][disability caused by or related to any condition, treatment, body part, or system specifically excluded by a Special Exception Rider.]

[22.] [disability caused by or contributed by a complication of a Sickness, Injury, or medical treatment or services that are not covered under this policy.]

V. CLAIM PROVISIONS

Notice of Claim

You must notify Us of the claim within [20-90] [calendar][business] days after the start of an Eligible Disability Period, or as soon as reasonably possible[, by calling Our Home Office]. When providing notice of claim, You must include Your name, address, and policy number. .

Claim Forms

Within [15-30] [calendar][business] days after We receive Your notice of claim, We will provide claim forms to be used when submitting Proof of Loss. The forms must be completed and sent to Us or Our designee. If You do not receive the claim forms within [15-30] [calendar][business] days, we will accept a written description of the exact nature and extent of the loss as Proof of Loss provided it meets the requirements, including timeframes, for submitting Proof of Loss stated below.

Proof of Loss

We must receive written or electronic proof of loss for Total [or Partial] Disability due to a [Non-Work Related]Sickness or an Injury [or pregnancy or childbirth]for which the claim is made. Proof of loss must be provided to Us within [90-180] calendar days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date the [Eligible Disability Period or Maximum Benefit Period ends, whichever is later,][Proof of Loss is otherwise required,] unless You are declared incompetent by a court of law.

The proof of loss must include all of the following:

- 1) Your name, address and policy number.
- 2) Verification of Your income and occupation.
- 3) The details and supporting medical documentation of the loss for which claim is made.

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us.

Right to Collect Information

To determine Our liability, We may request additional information from a Policyholder, Health Care Practitioner, facility, or other individual or entity. A Policyholder must cooperate with Us, and assist Us by obtaining the following information within [30-90][calendar][business] days of Our request. Benefits will be denied if We are unable to determine Our liability because a Policyholder, Health Care Practitioner, facility, or other individual or entity failed to:

1. Authorize the release of all medical records to Us and other information We requested.
2. Provide Us with information We requested about pending claims or other insurance coverage.
3. Provide Us with information as required by any contract with Us.
4. Provide Us with information that is accurate and complete.

5. Have any examination completed as requested by Us.
6. Provide reasonable cooperation to any requests made by Us.

Upon receipt of information allowing the determination of Our liability, We will reopen any claim for benefits. No claim for benefits can be reopened after [180-540] [calendar][business] days.

Physical Examination Medical Review and Autopsy

We have the right to have a Health Care Practitioner of Our choice conduct a review of medical records and/or examine a Policyholder at any time regarding a claim for benefits or to verify any claim of Total [or Partial] Disability. Health Care Practitioner charges for these reviews and/or exams will be paid by Us. We also have the right, in case of death, to have an autopsy done, at Our expense, where it is not prohibited by law.

Payment of Benefits

When We receive due written proof of the disability and determine Our liability, benefits will be paid to the Policyholder [once a week][every 2 weeks][at least once per month], but will be determined by the actual number of calendar days You are Totally Disabled [or Partially Disabled] in accordance with the Short Term Disability Income Insurance Benefits section. Any benefits unpaid at Your death will be paid at Our option to Your spouse, Your estate or the providers of the services. Benefits may not be assigned.

Any amount We pay will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for coverage of a Sickness or an Injury. It also does not constitute any assumption of liability for further coverage. Any benefit paid in error may be recovered from You or the person or entity receiving the incorrect payment. We may offset the overpayment against future benefit payments.

Rights of Administration

We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.

Claims Involving Fraud or Misrepresentation

Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Policyholder or a Policyholder's representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved fraud or misrepresentation, We will be entitled to a refund from You, the Beneficiary or the person receiving the payment.

If the Policyholder, or anyone acting on the Policyholder's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Policyholder may be subject to civil and/or criminal penalties.

Claim Appeal

You have the right to request a review of all adverse claim decisions. A review must be requested by writing to Us at Our Home Office within 180 [calendar][business] days following Your receipt of the notice that the claim was denied or reduced.

VI. PREMIUM PROVISIONS

Consideration

This plan is issued based on the statements and agreements in the Policyholder's application form, any exam of a Policyholder that is required, any other amendment or supplements to the application form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

Premium Payment

The initial premium must be paid [on or before the Effective Date for this coverage to be in force. Subsequent premiums are due] as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received [by] [Us][or][Our designee][in cash or check][or][by credit card or automatic charge to a bank account][at Our office] on [or before] the date due. [We may agree to accept premium payment in alternative forms[, such as credit card or automatic charge to a bank account].] If We tried to obtain payment for the amount due but were unsuccessful, We reserve the right to require an alternative form of payment during the grace period.

[Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] age, plan design, [smoking status,] and change in occupation. All premium adjustments will be made to individuals on the basis of shared characteristics. The mode of payment (monthly, quarterly or other) is subject to change, You will be notified at least 60 days in advance of any such change.]

Grace Period

There is a grace period of 31 calendar days for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the grace period ends.

Coverage will continue during the grace period unless You call Our office or give Us written notice to cancel the coverage. If a claim is payable during the grace period, any unpaid premiums due will be deducted from the claim payment.

[Suspension of Premium

If[, after the Effective Date,] You cease to be employed[on a Full-Time Basis][, due to [involuntary][or][voluntary]loss of employment,] We will suspend Your premium payments for the period of time You are not employed[on a Full-Time Basis], up to [60-365] calendar days. You must notify Us, in writing [or by calling Our Home Office,] when You cease working on a Full-Time Basis in order to suspend Your premium payments. Benefits are not payable during the period that You are not working on a Full-Time Basis. You must notify Us, in writing [or by calling Our Home Office,] when you resume employment on a Full-Time Basis to have Your coverage reinstated.]

Reinstatement

If any premium is not paid within the required time period, coverage for You will lapse. The coverage will be reinstated if all of the following requirements are met:

1. The lapse was not more than [30-365] calendar days.
2. You submit a supplemental application form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us.
3. We approve Your application form for reinstatement.

The coverage will be reinstated on the date We approve Your application form for reinstatement, but no later than 45 days after receipt of the reinstatement application, unless We have provided written notice of disapproval to You.. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

If the coverage is reinstated, the policy is subject to a new Pre-Existing Condition period that begins on the date that We approve Your application form for reinstatement.

A reinstated policy will only cover loss resulting from a[n] [Non-Work Related]Injury if it is sustained after the date of reinstatement. Loss resulting from [Non-Work Related]Sickness [or pregnancy] will be covered only for disability commencing after 10 days following the date of reinstatement. No benefits will be paid for any such condition and related complications if prior to the reinstatement date:

1. Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed regardless of whether the condition was diagnosed or not diagnosed; or
2. The condition produced signs or symptoms that were significant enough to establish manifestation or onset by one of the following tests:
 - a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
 - b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

[A pregnancy that exists on the day before the reinstatement date will be considered a Pre-Existing Condition.]

This limitation will apply until coverage has been in force for [12-24] months after the reinstatement date. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.]

In all other respects, You and Our Company will have the same rights as existed under this policy before the coverage lapsed, subject to any provisions included with or attached to this policy in connection with the reinstatement.

VII. RECOVERY PROVISIONS

Overpayment

If a benefit is paid under this policy and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You or Your estate/Beneficiary. We may offset the overpayment against future benefit payments.

[Subrogation Right]

Subrogation is the process by which We seek reimbursement from another person or entity for a claim We have already paid. When benefits are paid on Your behalf under this policy, We are subrogated to all rights of recovery You have against any person, entity or other insurance coverage. This includes, but is not limited to, recoveries against:

- [1.] [A third party.]
- [2.] [Any liability coverage for a third party.]
- [3.] [Other insurance that You have, including uninsured or underinsured motorist coverage.]

This subrogation right extends to the proceeds of any settlement or judgment but is limited to the amount of benefits We have paid.

You must:

- 1. Do nothing to prejudice or hinder any right of recovery; and
- 2. Execute and deliver any instruments and papers that may be required by Us; and
- 3. Cooperate with Us to assist Us in securing Our subrogation rights.

If You bring a lawsuit or other proceeding to recover damages in connection with a disability resulting in loss of income for which We have paid benefits under this plan, You or Your attorney must provide Us with copies of all pleadings, notices and other documents and papers that are related to Our subrogation right under this plan. We reserve the right to intervene in any proceeding in which You are a party to the extent that such intervention is reasonably necessary to protect or execute Our subrogation right.

Upon recovery of any portion of Our subrogation interest by way of settlement or judgment, We will not be required, under any circumstances, to pay a fee to Your attorney or share in any costs incurred by You and/or Your attorney in bringing about the settlement or judgment. If We engage an attorney or other agent for the purpose of enforcing Our subrogation right, We will be entitled to an award of Our costs including, without limitation, reasonable attorneys' fees associated with all trial and appellate proceedings.

You are not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this plan.

If We are precluded from exercising Our subrogation right, We may exercise Our Right to Reimbursement provision in this plan.]

[Right to Reimbursement

When We pay benefits under this plan, We have the right to recover an amount equal to the amount We paid if You:

1. Seek recourse against any person, entity or other insurance coverage by suit, settlement, judgment or otherwise; and
2. Recover payment, in whole or in part, from any person, entity or other insurance coverage for the benefits that We previously paid under this plan.

This right to reimbursement extends to the proceeds of any settlement or judgment. This includes, but is not limited to, recoveries against:

- [1.] [A third party.]
- [2.] [Any liability coverage for a third party.]
- [3.] [Other insurance that You have, including uninsured or underinsured motorist coverage.]]

Reimbursement to Us will not exceed either the amount of benefits that We paid under this plan that You recovered from any other person, entity or other insurance coverage or the amount recovered from any other person, entity or other insurance coverage as payment for the same loss of income, whichever is less.

You must reimburse Us for any payments that We make prior to a determination as to whether a disability is work-related at the time that You receive payment for the loss of income from another source. You must agree to:

1. Notify Us of any workers' compensation claim that You make; and
2. Reimburse Us even when workers' compensation benefits are provided by means of a settlement or compromise.
3. Cooperate with Us to assist Us in securing Our right to reimbursement.

You must provide Us with timely written notification in the event that You suffer a disability in which a third party might be responsible and You seek recourse against any person, entity or other insurance coverage by suit, settlement, judgment or otherwise.

Such a notice must inform Us of:

1. The nature of the disability; and

2. The names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages or loss suffered by You; and
3. A description of the Accident or occurrence that You reasonably believe was responsible for the disability at issue and the approximate date(s) upon which such Accident or occurrence happened; and
4. The name of any legal counsel retained by You in connection with any such Accident or occurrence.

If You bring a lawsuit or other proceeding to recover damages in connection with any such Accident or occurrence, You or Your attorney must provide Us with copies of all pleadings, notices and other documents and papers that are related to Our right to reimbursement under this plan. We reserve the right to intervene in any proceeding in which You are a party to the extent that such intervention is reasonably necessary to protect or execute Our right to reimbursement under this plan.

Upon recovery of any portion of Our right to reimbursement interest by way of settlement or judgment, We will not be required, under any circumstances, to pay a fee to Your attorney or share in any costs incurred by You and/or Your attorney in bringing about the settlement or judgment. If We engage an attorney or other agent for the purpose of enforcing Our right to reimbursement, We will be entitled to an award of Our costs including, without limitation, reasonable attorneys' fees associated with all trial and appellate proceedings.

You are not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this plan.]

[Workers' Compensation Not Affected

Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.]

VIII. OTHER PROVISIONS

Policy Changes

No change in the policy will be valid unless approved by one of Our executive officers and included with this policy. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable application or application requirements.

Modification of Your Coverage

We may modify the insurance coverage for You under this policy at any time. This modification will be consistent with state law and will apply uniformly to all policies with Your plan of coverage. You will be notified of any change.

Clerical Error

If a clerical error is made by Us, it will not affect the insurance to which a Policyholder is entitled.

Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this policy.

The premium charges will be adjusted as required, but not for more than two years prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within 60 days of Our notifying You of the error.

[Change of Occupation

If the Policyholder changes his or her occupation to one classified by Us as more or less hazardous than that stated [in this policy][on the application], We, upon receipt of proof of change of occupation, may reduce or increase the premium rate accordingly, from the date we receive proof of change of occupation. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by Us prior to the date of proof of change in occupation with the state official having supervision of insurance in the state where the Policyholder resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by Us in such state prior to the date of proof of change in occupation.]

Conformity with Statutes

If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary. If payment of the benefits under this plan would violate any U.S. economic or trade sanctions, such coverage will be null and void.

Enforcement of Plan Provisions

Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

Entire Contract

This policy is issued to the Policyholder. The entire contract of insurance includes the policy, the benefit schedule, the Policyholder's application/application form, and any riders and endorsements to this plan.

[Incentives, Rebates and Contributions

We may elect to furnish or participate in programs with other organizations that furnish individual applicants for coverage or Policyholders that meet common criteria or requirements determined by Us with "premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted or where other gifts or items of value may be offered or provided to You at no charge or a discount at a time or times or for a period determined by Us.]

Misstatements

If a Policyholder's material information, including but not limited to occupation, age or income, has been misstated and the premium or benefit amount would have been different had the correct information been disclosed, an adjustment in premiums or benefit level will be made based on the corrected information. In addition to adjusting future premiums, We will require payment of past premiums at the adjusted rate to continue coverage. If the Policyholder's age or occupation is misstated and coverage would not have been issued based on the Policyholder's true age or occupation, Our sole liability will be to refund all of the premiums paid for that Policyholder's coverage, minus the amount of any benefits paid by Us.

[Representations Made on Application

A copy of the application form will be included when the policy is issued. All statements made on the application form will be deemed representations and not warranties. No statement made in the application form will be used in any suit or action at law or equity unless a copy of the application form is furnished to the Policyholder, or in the event of death or incapacity of the Policyholder, a copy will be furnished to the Policyholder's beneficiary or personal representative.]

Rescission of Insurance and/or Denial of Claim and Time Limit on Certain Defenses

Within the first three years after the Effective Date of coverage, We have the right to rescind or modify Your policy of insurance coverage and/or deny a claim for a Policyholder if the application form contains an omission or misrepresentation, whether intended or not, which We determine to be material. After three years from the Effective Date of this Policy, no misstatements, except fraudulent misstatements or omissions, made by the applicant in the applications/enrollment form for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such three-year period.

Legal Action

No suit or action at law or in equity may be brought to recover benefits under this plan until the expiration of 60 days after Proof of Loss has been furnished in accordance with the requirements of this Policy. You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review

process. No suit or action at law or in equity can be brought later than 3 years from the date proof of loss was required.

Forum

Any lawsuits or disputes arising under the terms of the Policy must be brought in the United States District Court for the Eastern District of Wisconsin.

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

SHORT TERM DISABILITY INCOME INSURANCE
BENEFIT SCHEDULE

This policy insures for loss of income of the Policyholder when employed on a Full-Time Basis. This plan does not pay benefits when income [from Your Primary Occupation] does not exist prior to the date of disability. Read Your policy carefully.

| | | | |
|-------------------|--------------|-----------------------------|----------------|
| POLICYHOLDER | [John Doe] | [INITIAL ANNUAL PREMIUM:] | [\$XXX.XX] |
| POLICY NUMBER | [0000001] | [INITIAL TERMINATION DATE:] | [XX/XX/XX] |
| EFFECTIVE DATE | [00/00/0000] | [PAYMENT OPTION:] | [PAYMENT MODE] |
| [LOCATION NUMBER] | [001] | [[MODE] PREMIUM:] | [\$XXX.XX] |

This Schedule contains limited information about Your plan. PLEASE READ YOUR POLICY CAREFULLY.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.] Benefits are payable for only one Eligible Disability Period at a time, even if Total [or Partial] Disability is caused by concurrent [Non-Work Related] [Sickness or Injury][or pregnancy or childbirth]. Elimination Period restrictions apply to all Eligible Disability Periods.

MONTHLY BENEFIT: [\$XXX.XX]

ELIMINATION PERIOD – Injury: [XXX DAYS]

ELIMINATION PERIOD – Sickness: [XXX DAYS]

MAXIMUM BENEFIT PERIOD: [[4-104] weeks][[30-730]days] per Eligible Disability Period for [Non-Work Related] Sickness or Injury.

[[[4-52] weeks][[30-365] days] per Eligible Disability Period for pregnancy.

[[4-52] weeks][[30-365] days] per Eligible Disability Period for childbirth.

The Maximum Benefit Period for pregnancy or childbirth may be extended to the term of Maximum Benefit Period for [Non-Work Related] Sickness or Injury stated above if You provide proof of continued disability beyond the period for pregnancy or childbirth.]

[Included: Optional Work Related Sickness or Injury disability benefits]

[This policy provides benefits for disability caused by Non-Work Related Sickness or Injury only.]

[AGENT INFORMATION:]

[Name

Address & Telephone Number]

Policy #: _____

Acceptance of Offer and Attestation

I represent to the best of my knowledge and belief, that all statements and answers on this application form are complete and true. My recorded Personal Health History, the application form and any amendments shall be the basis for the offer of coverage. I also agree that:

[Except as otherwise provided in the Conditional Receipt], [T][t]he insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. I shall sign the application form [and] [obtain the signature of my [Spouse] [Domestic Partner] [Civil Union] and any covered dependents over the age of 18], and return it to Time Insurance Company within [30] days of the contract issue. If acceptance is not received within [30] days, Time Insurance Company reserves the right to revoke any and all such offers. [The first full premium must be paid.] [The contract may only be effective prior to the contract delivery and acceptance, if all the terms of the Conditional Receipt have been fulfilled.]

I agree that a photocopy of this authorization shall be valid for two years from the date signed. I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, [the notification regarding the Medical Information Bureau,] the Privacy statement concerning my personal health information, the Abbreviated Notice of Insurance Information Practices, and the Outline of Coverage for Health Insurance, if required.

[I] [We], the undersigned proposed insured[(s)] and agent acknowledge that the proposed insured[(s)] has read the completed application form. We understand and acknowledge that any fraudulent statement or material misrepresentation on the application form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

Signature of Proposed Insured

Date Signed

State

[Signature of Spouse or Other Insured]

[Signature(s) of Other Dependents 18 or Over]

[Guardian's Signature]

If Life Insurance is issued, complete this section.

Beneficiary for Primary Insured:

Full Name and Relationship

Contingent Beneficiary:

Full Name and Relationship

*(The Primary Insured is the Beneficiary of any spouse[/domestic partner]
[/civil union] or child(ren) life insurance.)*

Application Form for Short-Term Disability Insurance [with] [Optional Coverage[s]]

AGENT/AGENCY INFORMATION

PLEASE PRINT IN BLACK INK

Agent Name: _____ Phone Number: _____
Agent Number: _____ E-mail Address: _____
Key Agency Contact: _____ Agency Name: _____
Fax Number: _____ Agency Number: _____

[Policy should be mailed to:] ☐ Agent ☐ Agency ☐ Policyholder]

TYPE OF ACTIVITY (Please check appropriate box.)

☐ NEW] [If not a new applicant, check appropriate box and list affected policy number.]

☐ CHANGE/ADDITION TO AN EXISTING POLICY. POLICY # _____]

| | |
|---|---|
| <input type="checkbox"/> Internal Replacement] | <input type="checkbox"/> Removal/Reduction of Special Class Premium] |
| <input type="checkbox"/> Adding Dependent] | <input type="checkbox"/> Conversion (over age dependent/divorce] |
| <input type="checkbox"/> Removal of Tobacco Rates] | <input type="checkbox"/> Policy/Benefit Change To An Existing Policy] |
| <input type="checkbox"/> Applying for Preferred Rates] | <input type="checkbox"/> [List Type if Change Requested: _____] |
| <input type="checkbox"/> Removal of [Condition Specific Deductible] [or] [Special Exception Rider]] | <input type="checkbox"/> Reinstatement of Coverage] |

REQUESTED EFFECTIVE DATE

Requested effective date _____

[A policy may not have an effective date of the 29th, 30th, or 31st.] [Your effective date is based on the date [you sign] [we receive] your application form.] [If [you sign] [we receive] it on the [1st] through the [15th] of the month, your effective date will be the [1st] of the [following] month. If [you sign] [we receive] the application form on the [16th] through the [31st] of the month, your effective date will be the [15th] of the [following] month.] [Check with your agent for more details.]]

PERSON[S] TO BE INSURED

| | Last | Name First | MI | Sex | Age | Birthdate (MM/DD/YY) | Height | Weight | Social Security Number |
|---|------|---------------|----|-----|-----|-------------------------|--------|--------|------------------------|
| 1. [Primary] [Proposed] [Insured] | | | | | | | | | |
| [2.] [Spouse][Domestic Partner][Civil Union] | | | | | | | | | |

3. Resident Address: _____
(No P.O. Boxes) (Street) (City) (State) (Zip)

[4.] Phone Number (with area code): _____ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. _____]

5. Email Address: _____

[6.] [Is the [Primary] [Proposed] [Insured] a U.S. citizen or Lawful Permanent Resident/Green Card Holder? ☐ Yes ☐ No]

[7a.] [[Primary] [Proposed] [Insured] Primary Occupation: _____]

[Duties: _____]

[7b.] [[Primary] [Proposed] [Insured] Primary Industry: _____] [Standard Industrial Classification (SIC) code: _____]

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[7c.] [Primary Employer's Name: _____]
 [Employer's Phone Number: (_____) _____]
 [Employer's Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)]

[7d.] [Length of employment with above named company? _____ Years _____ Months]

[7e.] [Does the [Primary] [Proposed] [Insured] work [1-40] [or] [more] hours per week at their primary occupation?..... ☐ Yes ☐ No]

[7f.] [Does the [Primary] [Proposed] [Insured] work [1-52] [or] [more] weeks per year at their primary occupation?..... ☐ Yes ☐ No]

[7g.] [Is the [Primary] [Proposed] [Insured] [self-employed] [or] [a sole proprietor]?..... ☐ Yes ☐ No]

[7h.] [Does the [Primary] [Proposed] [Insured] have a secondary or part-time occupation? ☐ Yes ☐ No]

[If "Yes," [Primary] [Proposed] [Insured]'s Secondary Occupation: _____]

[Duties: _____]

[7i.] [Is the [Primary] [Proposed] [Insured] covered by Workers' Compensation?..... ☐ Yes ☐ No]

[If you answered "Yes" to question [7i], you are not eligible for the optional Work Related Sickness or Injury coverage; therefore the optional coverage will not be issued.]

[7j.] [[Primary] [Proposed] [Insured]'s gross annual income (without overtime, unless contractual, bonuses or other incentives) for full-time job is (If self-employed, gross annual income is net income.) \$ _____]
 (Net income or net earnings is gross or total sales minus taxes, interest, depreciation, and other expenses.)

[Annual income must be \$[1,000 - 20,000] or greater for coverage to be issued.]

OTHER COVERAGE IN FORCE

[8.] [[Are any of] [Is] the [Primary] [Proposed] [Insured][s] covered by, or has application been made for any type of [short term] [disability] [or] [medical] insurance?..... ☐ Yes ☐ No]

[If "Yes," complete the section below.

| Insurance Company Name | Policy Number | Monthly benefit amount | Benefit Period | Elimination Period | Effective Date (MM/DD/YY) | Is this coverage being replaced by proposed coverage? |
|------------------------|---------------|------------------------|----------------|--------------------|---------------------------|---|
| | | | | | | |
| | | | | | | |

[9.] [Were all] [Was the] Proposed Insured[s] covered under the prior plan listed above? ☐ Yes ☐ No]

[If "No," list those not covered. _____]

[10.] [[Have any of] [Has] the [Primary] [Proposed] [Insured][s] [within the last [1-10] years] been declined, postponed, rescinded, reformed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance? ☐ Yes ☐ No]

[If "Yes," give details. _____]

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HAZARDOUS ACTIVITIES AND DRIVING

- [11.] [In the last [1-10] years, [have any of] [has] the [primary] [proposed] [insured][s] participated in any motorized [or non-motorized] vehicle racing (includes [stunt show or speed test,] drivers, pit crew, owners or mechanics) or any of the following activities: [cave exploration,] [boxing,] [bungee jumping,] [hot-air ballooning,] [professional or semi-professional sports,] [parkour,] [free running,] [extreme sports,] [skydiving,] [ultra light flying,] [parachute jumping,] [hang-gliding,] [parakiting,] [parasailing,] [sail gliding,] [scuba diving,] [hang gliding,] [rock or mountain climbing,] [horse riding,] [or] [rodeo participation]?..... ☐ Yes ☐ No]
- [If "Yes," was it a one-time event with no current or future participation? ☐ Yes ☐ No]
- [12.] [Has the [primary] [proposed] [insured] [ever] flown, or is the [primary] [proposed] [insured] planning to fly, as pilot, crew member or student?..... ☐ Yes ☐ No]
- [13.] [Does the [primary] [proposed] [insured] have a valid driver's license? ☐ Yes ☐ No]
- [If "Yes" list state of issue and number: _____]
- [14.] [In the last [1-10] years, [have any of] [has] the [primary] [proposed] [insured][s] been cited for operating a motor vehicle under the influence of alcohol or drugs, [had more than [1-5] moving violations] [or] [had their driver's license suspended or revoked]?..... ☐ Yes ☐ No]

HEALTH STATEMENT

IMPORTANT! IF QUESTIONS 18 - 32 ARE ANSWERED "YES," PLEASE GIVE COMPLETE DETAIL ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.

- [15.] [Is the [primary] [proposed] [adult] [insured] currently on leave, not working, or unable to perform any material or substantial duties of their job because of their sickness, [maternity] or injury? ☐ Yes ☐ No]
- [16.] [Has the [primary] [proposed] [insured] ever needed assistance or personal supervision to perform any activities of daily living (toileting, transferring, continence, eating, bathing or dressing)? ☐ Yes ☐ No]
- [17.] [Has the [primary] [proposed] [insured] ever been diagnosed with or ever treated for any of the following: ☐ Yes ☐ No]
- | | | | |
|-----------------------------------|---|--|--|
| [• AIDS/HIV] | [• Crohn's disease] | [• Liver disorders, excluding fully recovered Hepatitis A] | [• Schizophrenia] |
| [• Alzheimer's Disease/ Dementia] | [• Congestive heart failure] | [• Mixed Connective Tissue Disease] | [• Sickle Cell Anemia] |
| [• Aneurysm] | [• Diabetes, excluding Gestational Diabetes] | [• Multiple Sclerosis (MS)] | [• Stroke or TIA] |
| [• Angina (Chest pain)] | [• Emphysema or Chronic Obstructive Pulmonary Disease (COPD)] | [• Polyneuropathy] | [• Systemic lupus] |
| [• Arteriosclerosis] | [• Fibromyalgia] | [• Psoriatic arthritis] | [• Ulcerative colitis] |
| [• Bipolar Disorder] | [• Kidney disorders, excluding kidney stones] | [• Pulmonary Fibrosis] | [• Any condition that resulted in Bariatric Surgery] |
| [• Cardiomyopathy] | | [• Rheumatoid arthritis] | |
| [• Coronary artery disease] | | | |

[If you answered "Yes" to question [15], [16] [or] [17], coverage will not be issued; therefore, do not submit this application.]

- [18.] [Within the last [[1-5] years] [[1-12] months], has the [primary] [proposed] [insured] missed [1-10] consecutive days or [1-10] total days of work because of [their] [your] sickness or injury for which symptoms existed? [Do NOT include routine childbirth.].. ☐ Yes ☐ No]
- [19.] [Within the last [[1-5] years] [[1-12] months], has the [primary] [proposed] [insured] experienced symptoms, been diagnosed as having or been treated for an injury or disorder to the back, the neck or a joint? ☐ Yes ☐ No]

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[20.] [Within the last [[1-5] years] [[1-12] months], has the [primary] [proposed] [insured] received disability benefits or claimed Workers' Compensation? ☐ Yes ☐ No]

For Questions 21-33, WITHIN THE LAST [1-10] YEARS, HAS [ANY] [THE] [PRIMARY] [PROPOSED] [INSURED]:
[Note: any follow-up visits in the last [1-10] years as a result of a diagnosis over [1-10] years ago must be disclosed.]

[21.] [Had surgery in a hospital or outpatient facility? ☐ Yes ☐ No]

[22.] [Had medical treatment [in a hospital or outpatient facility] [other than already disclosed]? ☐ Yes ☐ No]

[23.] [Had any urgent care or emergency room visits [not disclosed in Questions [21] & [22]]? ☐ Yes ☐ No]

[24.] [Received treatment, testing, consulted with or received a diagnosis from a physician or other healthcare provider [other than already disclosed]? [Do NOT include any physical exams.] ☐ Yes ☐ No]

[25.] [Had any testing [with abnormal findings] or tests from which you have not received results [other than already disclosed]? ☐ Yes ☐ No]

[26.] [Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed? ☐ Yes ☐ No]

[27.] [Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups? ☐ Yes ☐ No]

[28.] [Used illegal drugs, or prescription medications other than as prescribed, or been advised by a physician or other healthcare provider to discontinue or decrease alcohol consumption or drug use? ☐ Yes ☐ No]

Additional Questions

[29.] [Has [the] [any] [primary] [proposed] [adult] [insured] [ever] taken or been advised to take any prescription medication [in the last [[1-10] years] [[1-12] months]]? ☐ Yes ☐ No]
 [If "Yes," please give complete details below

| Last | Name First | MI | Name of Medication | Dosage and Frequency of Use | Date Prescribed | Date Last Used | Condition(s) Being Used For |
|------|---------------|----|-----------------------|--------------------------------|-----------------|----------------|--------------------------------|
| | | | | | | | |
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[30.] [Has [the] [any] [primary] [proposed] [adult] [insured] [ever] used tobacco products in any form or nicotine substitutes [within the last [[1-10] years] [[1-12] months]] [after the age of [21]]? ☐ Yes ☐ No]

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[31.] [Has [any] [the] [primary] [proposed] [insured] had a diagnosis, [or] treatment] [or follow-up] for cancer in the last [1-10] years? ☐ Yes ☐ No]

[32.] [Is [any] [the] [primary] [proposed] [insured] currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy? [This includes a surrogate mother or any person that she is contracted with.]..... ☐ Yes ☐ No]

[33.] [Have you fully disclosed all medical conditions for you [and your family] within the last [1-10] years?..... ☐ Yes ☐ No]

OTHER PHYSICIANS

[Physician or Healthcare Provider seen in the last [1-10] years [for] [each] [primary] [proposed] [insured] [other than disclosed above]. Attach a separate sheet if additional space is needed. Sign and date any additional sheets.

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____]

FAX ALL PAGES TO [866.387.0486]

Assurant Health 501 West Michigan Milwaukee, WI 53203 [Fax 414.299.6020]

[ADDITIONAL MEDICAL DETAILS

IMPORTANT! IF QUESTIONS 18-32 ARE ANSWERED "YES," PLEASE GIVE COMPLETE DETAILS BELOW.

Attach a separate sheet if additional space is needed. Sign and date any additional sheets.

| | Last | Name First | MI | Provide Dates, Type of Treatment, Diagnosis or Condition, Results | Full Recovery? | Name of Doctor or Hospital, and Complete Address and Phone Number |
|-------------|------|---------------|----|---|---|---|
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

FAX ALL PAGES TO [866.387.0486]

Assurant Health 501 West Michigan Milwaukee, WI 53203 [Fax 414.299.6020]

[**HIPAA ELIGIBILITY**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the below statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
 - Your most recent coverage was under a group plan, a governmental plan or a church plan.
 - You are not covered under another group health plan.
 - Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
 - You are not currently eligible for Medicare or Medicaid.
 - You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.
- ☐ No, I or anyone to be insured do not meet any of the above requirements.
- ☐ Yes, I or anyone to be insured meet all of the above requirements.]

[**EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

You understand and agree that you are applying for [individual] [supplemental] short term disability insurance for you [(and your family)]. [You further understand that this application for [supplemental] short term disability insurance [will] [may] [be] [fully] [medically] [underwritten] [,] [and] [is subject to eligibility requirements] [and that coverage is not guaranteed].] You are personally paying the entire premium for this [supplemental] [health] [short term disability] [term life] [vision] insurance coverage.

Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

[[If my employer has [2]-[50] full-time employees,] I agree that I will not use [employer contributions] [or] [funds from a [Health Reimbursement Arrangement] [(HRA)] [or a Cafeteria Plan]] to pay the premium for my individual coverage.]

Do you agree with this statement? ☐ Yes ☐ No]

[AUTHORIZATION

[In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me [or my family] as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.]

[I represent to the best of my knowledge and belief, that all statements and answers on this application form are complete and true. The application form and any amendments shall be the basis for the contract. I also agree that: (1) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the application form information with a signature and returning that signed acceptance to Time Insurance Company. (2) [Except as otherwise provided in the Conditional Receipt,][T][t]he insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me.] (3) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (4) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.]

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or application determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for application.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of application, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.]]

Signature of Primary Proposed Insured _____ Date Signed _____ Time Signed _____ a.m./p.m. _____ City _____ State _____

Requested Effective Date: _____

[Premium Amount Sent: \$_____]

[Conditional Receipt Taken: ☐ Yes ☐ No]

Attention: (Agent)

I have reviewed this application form to ensure that all required items have been completed. Are you aware of any mental or physical impairment, disease, or deformity of any [primary] [proposed] [insured] which is not disclosed on the application form? ☐ Yes ☐ No

If "Yes," please explain. _____

Licensed Resident Agent's Signature

Print Agent's Name

Initial here if you witnessed the signing of this form by the [primary] [proposed] [insured].

FAX ALL PAGES TO [866.387.0486]

Assurant Health 501 West Michigan Milwaukee, WI 53203 [Fax 414.299.6020]

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

Form 30044 (10/2009)

IMPORTANT NOTICES - LEAVE WITH CUSTOMER

[NOTIFICATION REGARDING ("MIB") formerly known as the MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.]

[ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.]

[FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.]

[PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on application forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]]

CONDITIONAL RECEIPT

This Conditional Receipt is received from _____,
this _____ day of _____ (month) _____ (year).

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which the Personal Health History call is completed.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned. If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company received the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.]

LEAVE THIS PAGE WITH THE CUSTOMER — DO NOT FAX

Assurant Health 501 West Michigan Milwaukee, WI 53203

Tele-App Part 1 Application Form for [Accident] [Cancer] [Critical Illness] [Dental] [Heart & Stroke] [Hospital Indemnity] [Short Term Disability] [Sickness Indemnity] [Term Life] [Vision] Insurance [With] [Optional Coverage[s]]

AGENT/AGENCY INFORMATION

PLEASE PRINT IN BLACK INK

Agent Name: _____ Phone Number: _____
 Agent Number: _____ E-mail Address: _____
 Key Agency Contact: _____ Agency Name: _____
 Fax Number: _____ Agency Number: _____

[Policy should be mailed to:] ☐ Agent ☐ Agency ☐ Policyholder]

TYPE OF ACTIVITY (Please check appropriate box.)

☐ NEW [If not a new applicant, check appropriate box and list affected policy number.]

☐ CHANGE/ADDITION TO AN EXISTING POLICY. POLICY # _____]

| | |
|---|---|
| <input type="checkbox"/> Internal Replacement <input type="checkbox"/> Adding Dependent <input type="checkbox"/> Removal of Tobacco Rates <input type="checkbox"/> Applying for Preferred Rates <input type="checkbox"/> Removal of [Condition Specific Deductible] [or] [Special Exception Rider]] | <input type="checkbox"/> Removal/Reduction of Special Class Premium <input type="checkbox"/> Conversion (over age dependent/divorce) <input type="checkbox"/> Policy/Benefit Change To An Existing Policy [List Type if Change Requested: _____] <input type="checkbox"/> Reinstatement of Coverage |
|---|---|

PERSON[S] TO BE INSURED

| | Last | Name First | MI | Sex | Age | Birthdate (MM/DD/YY) | State of Birth | Height | Weight | Social Security Number |
|--|------|---------------|----|-----|-----|-------------------------|-----------------------|--------|--------|---------------------------|
| [1.] [PRIMARY] [PROPOSED] [INSURED] | | | | | | | | | | |
| [2.] [SPOUSE][/ DOMESTIC PARTNER][/ CIVIL UNION] | | | | | | | | | | |
| [3.] [DEPENDENT(S)] (list relationship) | Last | Name First | MI | Sex | Age | Birthdate (MM/DD/YY) | Full-time Student? | Height | Weight | Social Security Number |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

[4.] Resident Address: _____
 (NO P.O. BOXES) (Street) (City) (State) (Zip)

[5.] [Phone Number (with area code): _____]

[6.] [Email Address: _____]

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

Assurant Health 501 West Michigan Milwaukee, WI 53203

OTHER COVERAGE IN FORCE

[7.] [[Are any of][Is] the [Primary] [Proposed] [Insured][s] covered by any type of [accident,] [cancer,] [critical illness,] [dental,] [hospital indemnity,] [term life,] [disability,] [short term disability,] [medical,] [heart/stroke,] [sickness indemnity,] [or] [vision] insurance]?..... ☐ Yes (complete the section below)
☐ No [(go to BILLING)]

| Proposed Insured's Name | Insurance Company Name | Group or Individual | Type of Coverage | Effective Date (MM/DD/YY) | Termination Date (MM/DD/YY) | Is this coverage being replaced by proposed coverage? |
|-------------------------|------------------------|---------------------|------------------|---------------------------|-----------------------------|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

[8.] [Is the [Primary] [Proposed] [Insured] a U.S. citizen or Lawful Permanent Resident/Green Card Holder?..... ☐ Yes ☐ No]

[9a.] [[Primary] [Proposed] [Insured] Primary Occupation: _____]

[Duties: _____]

[9b.] [Primary] [Proposed] [Insured] Primary Industry: _____ [Standard Industrial Classification (SIC) code: _____]

[9c.] [Company Name: _____] [Work Number: (_____) _____]

[9d.] [Length of employment with above named company? _____ Years _____ Months]

[9e.] [Does the [Primary] [Proposed] [Insured] work [1-40] [or] [more] hours per week at their primary occupation?. ☐ Yes ☐ No]

[9f.] [Does the [Primary] [Proposed] [Insured] work [1-52] [or] [more] weeks per year at their primary occupation?. ☐ Yes ☐ No]

[9g.] [Is the [Primary] [Proposed] [Insured] [self-employed] [or] [a sole proprietor]? ☐ Yes ☐ No]

[9h.] [Does the [Primary] [Proposed] [Insured] have a secondary or part-time occupation?..... ☐ Yes ☐ No]

[If "Yes," [Primary] [Proposed] [Insured]'s Secondary Occupation: _____]

[Duties: _____]

[9i.] [Is the [Primary] [Proposed] [Insured] covered by Workers' Compensation? ☐ Yes ☐ No]

[If you answered "Yes" to question [9i], you are not eligible for the optional Work Related Sickness or Injury coverage; therefore the optional coverage will not be issued.]

[9j.] [[Primary] [Proposed] [Insured]'s gross annual income (without overtime, unless contractual, bonuses or other incentives) for primary occupation is (If self-employed, gross annual income is net income.) \$]
 [(Net income or net earnings is gross or total sales minus taxes, interest, depreciation, and other expenses.)]

[Annual income must be \$[1,000 - 20,000] or greater for coverage to be issued.]

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

Assurant Health 501 West Michigan Milwaukee, WI 53203

[COMPLETE IF REQUESTING ACCIDENT OR LIFE INSURANCE COVERAGE

Beneficiary for [Primary] [Proposed] [Insured]: _____
(Full Name) (Relationship)

Contingent Beneficiary: _____
(Full Name) (Relationship)

The [Primary] [Proposed] [Insured] is the beneficiary of any Spouse [/Domestic Partner] [/Civil Union] or Child(ren) Life Insurance.]

[HIPAA ELIGIBILITY

[Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the below statements are true at the time you or anyone to be insured applies for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

☐ No, I or anyone to be insured do not meet any of the above requirements.

☐ Yes, I or anyone to be insured meet all of the above requirements.]]

[EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for [individual] [limited benefit] [supplemental] [health] [accident] [cancer] [dental] [critical illness] [heart and stroke] [hospital indemnity] [short term disability] [sickness indemnity] [term life] [vision] insurance for you [(and your family)]. [You further understand that this application for [limited benefit] [supplemental] [health] [accident] [cancer] [dental] [critical illness] [heart and stroke] [hospital indemnity] [short term disability] [sickness indemnity] [term life] [vision] insurance [will] [may] [be] [fully] [medically] [underwritten] [,] [and] [is subject to eligibility requirements] [and that coverage is not guaranteed].] You are personally paying the entire premium for this [supplemental] [health] [accident] [cancer] [dental] [critical illness] [heart and stroke] [hospital indemnity] [sickness indemnity] [short term disability] [term life] [vision] insurance coverage.

Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

[[If my employer has [2]-[50] full-time employees,] I agree that I will not use [employer contributions] [or] [funds from a [Health Reimbursement Arrangement] [(HRA)] [or a Cafeteria Plan]] to pay the premium for my individual coverage.]

Do you agree with this statement? ☐ Yes ☐ No]

AUTHORIZATION

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me [or my family] as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) I must call Time Insurance Company and complete the Personal Health History portion of the application process within 10 days of commencement of the application process and subsequently provide any and all medical information related thereto. (2) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the application form information with a signature and returning that signed acceptance to Time Insurance Company. (3) [Except as otherwise provided in the Conditional Receipt,] [T][t]he insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (4) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (5) If any-of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

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[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of application, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.]

| Signature of [Primary] [Proposed] [Insured] | | Date Signed | Time Signed | City & State |
|---|--|--|-------------|--------------|
| [_____] | | | | |
| [Signature of Spouse[/Domestic Partner] [/Civil Union] or Other (if proposed to be insured)] | | [Signature(s) of Other Dependent(s) 18 or Over (if proposed to be insured)] | | |

Requested Policy Effective Date: _____ [Conditional Receipt Given? ☐ Yes ☐ No]

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

Assurant Health 501 West Michigan Milwaukee, WI 53203

ADDITIONAL NOTICES

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Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

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[ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES]

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.]

[FRAUD NOTICE]

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[PRIVACY]

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on application forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]]

CONDITIONAL RECEIPT

This Conditional Receipt is received from _____, this _____ day of _____ (month) _____ (year).

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which the Personal Health History call is completed.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned. If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company received the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.]

LEAVE THIS PAGE WITH THE CUSTOMER — DO NOT FAX

Assurant Health 501 West Michigan Milwaukee, WI 53203

Part 2 Application Form for Short Term Disability Insurance [With] [Optional Coverage[s]]

AGENT/AGENCY INFORMATION

PLEASE PRINT IN BLACK INK

Agent Name: _____ Phone Number: _____
 Agent Number: _____ E-mail Address: _____
 Key Agency Contact: _____ Agency Name: _____
 Fax Number: _____ Agency Number: _____

[Policy should be mailed to:] ☐ Agent ☐ Agency ☐ Policyholder]

TYPE OF ACTIVITY (Please check appropriate box.)

☐ NEW] [If not a new applicant, check appropriate box and list affected policy number.]

| | |
|---|--|
| <input type="checkbox"/> CHANGE/ADDITION TO AN EXISTING POLICY. POLICY # _____] | |
| <input type="checkbox"/> Internal Replacement] <input type="checkbox"/> Adding Dependent] <input type="checkbox"/> Removal of Tobacco Rates] <input type="checkbox"/> Applying for Preferred Rates] <input type="checkbox"/> Removal of [Condition Specific Deductible] [or] [Special Exception Rider]] | <input type="checkbox"/> Removal/Reduction of Special Class Premium] <input type="checkbox"/> Conversion (over age dependent/divorce] <input type="checkbox"/> Policy/Benefit Change To An Existing Policy] [List Type if Change Requested: _____] <input type="checkbox"/> Reinstatement of Coverage] |

PERSON[S] TO BE INSURED

| | Last | Name First | MI | Sex | Age | Birthdate (MM/DD/YY) | State of Birth | Height | Weight | Social Security Number |
|---|------|---------------|----|-----|-----|-------------------------|-------------------|--------|--------|------------------------|
| 1. [Primary] [Proposed] [Insured] | | | | | | | | | | |
| [2.] [Spouse][Domestic Partner][Civil Union] | | | | | | | | | | |

[3a.] Resident Address: _____
 (No P.O. Boxes) (Street) (City) (State) (Zip)

[3b.] Email Address: _____

[4.] [Does [any] [the] [primary] [proposed] [insured] live outside the above household? ☐ Yes ☐ No]

If "Yes," explain. _____

[5.] Phone Number (with area code): _____ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. _____]

[6.] [Is the [Primary] [Proposed] [Insured] a U.S. citizen or Lawful Permanent Resident/
 Green Card Holder? ☐ Yes ☐ No]

[7a.] [[Primary] [Proposed] [Insured] Primary Occupation: _____]

[Duties: _____]

[7b.] [[Primary] [Proposed] [Insured] Primary Industry: _____] [Standard Industrial Classification (SIC) code: _____]

[7c.] [Primary Employer's Name: _____]
 [Employer's Phone Number: (_____) _____]
 [Employer's Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)]

[7d.] [Length of employment with above named company? _____ Years _____ Months]

[7e.] [Does the [Primary] [Proposed] [Insured] work [1-40] [or] [more] hours per week at their primary occupation?..... ☐ Yes ☐ No]

[7f.] [Does the [Primary] [Proposed] [Insured] work [1-52] [or] [more] weeks per year at their primary occupation?..... ☐ Yes ☐ No]

[7g.] [Is the [Primary] [Proposed] [Insured] [self-employed] [or] [a sole proprietor]? ☐ Yes ☐ No]

[7h.] [Does the [Primary] [Proposed] [Insured] have a secondary or part-time occupation?..... ☐ Yes ☐ No]

[If "Yes," [Primary] [Proposed] [Insured's] Secondary Occupation: _____]

[Duties: _____]

[7i.] [Is the [Primary] [Proposed] [Insured] covered by Workers' Compensation? ☐ Yes ☐ No]

[If you answered "Yes" to question [7i], you are not eligible for Work Related Sickness or Injury coverage; therefore the optional coverage will not be issued.]

[7j.] [[Primary] [Proposed] [Insured's] gross annual income (without overtime, unless contractual, bonuses or other incentives) for full-time job is (If self-employed, gross annual income is net income.) \$ _____]
 (Net income or net earnings is gross or total sales minus taxes, interest, depreciation, and other expenses.)

[Annual income must be \$[1,000 - \$20,000] or greater for coverage to be issued.]

[OTHER COVERAGE IN FORCE OR APPLIED FOR

[8.] [[Are any of] [Is] the [primary] [proposed] [insured][s] covered by, or has application been made for any type of [short term] [disability] [or] [medical] insurance?..... ☐ Yes ☐ No]
 [If "Yes," complete the section below.

| Insurance Company Name | Policy Number | Monthly benefit amount | Benefit Period | Elimination Period | Effective Date (MM/DD/YY) | Is this coverage being replaced by proposed coverage? |
|------------------------|---------------|------------------------|----------------|--------------------|---------------------------|---|
| | | | | | | |
| | | | | | | |

[9.] [Were all] [Was the] [primary] [proposed] [insured][s] covered under the prior plan listed above? ☐ Yes ☐ No]
 [If "No," list those not covered. _____]

[10.] [[Have any of] [Has] the [primary] [proposed] [insured][s] [within the last [1-10] years] been declined, postponed, rescinded, reformed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance? ☐ Yes ☐ No]
 [If "Yes," give details. _____]

HAZARDOUS ACTIVITIES AND DRIVING

- [11.] [In the last [1-10] years, [have any of] [has] the [primary] [proposed] [insured][s] participated in any motorized [or non-motorized] vehicle racing (includes [stunt show or speed test,] drivers, pit crew, owners or mechanics) or any of the following activities: [cave exploration,] [boxing,] [bungee jumping,] [hot-air ballooning,] [professional or semi-professional sports,] [parkour,] [free running,] [extreme sports,] [skydiving,] [ultra light flying,] [parachute jumping,] [hang-gliding,] [parakiting,] [parasailing,] [sail gliding,] [scuba diving,] [hang gliding,] [rock or mountain climbing,] [horse riding,] [or] [rodeo participation]?..... ☐ Yes ☐ No]
- [12.] [Has the [primary] [proposed] [insured] ever] flown, or is the [primary] [proposed] [insured] planning to fly, as pilot, crew member or student?..... ☐ Yes ☐ No]
- [13.] [Does the [primary] [proposed] [insured] have a valid driver's license? ☐ Yes ☐ No]
- [If "Yes" list state of issue and number: _____]
- [14.] [In the last [1-10] years, [have any of] [has] the [primary] [proposed] [insured][s] been cited for operating a motor vehicle under the influence of alcohol or drugs, [had more than [1-5] moving violations] [or] [had their driver's license suspended or revoked]?..... ☐ Yes ☐ No]

HEALTH STATEMENT

- [15.] [Is the [primary] [proposed] [adult] [insured] currently on leave, not working, or unable to perform any material or substantial duties of their job because of their sickness, [maternity] or injury? ☐ Yes ☐ No]
- [16.] [Has the [primary] [proposed] [insured] ever needed assistance or personal supervision to perform any activities of daily living (toileting, transferring, continence, eating, bathing or dressing)? ☐ Yes ☐ No]
- [17.] [Has the [primary] [proposed] [insured] ever been diagnosed with or ever treated for any of the following: ☐ Yes ☐ No]
- | | | | |
|--------------------------------------|---|--|--|
| [• AIDS/HIV] | [• Crohn's disease] | [• Liver disorders, excluding fully recovered Hepatitis A] | [• Schizophrenia] |
| [• Alzheimer's Disease/ Dementia] | [• Congestive heart failure] | [• Mixed Connective Tissue Disease] | [• Sickle Cell Anemia] |
| [• Aneurysm] | [• Diabetes, excluding Gestational Diabetes] | [• Multiple Sclerosis (MS)] | [• Stroke or TIA] |
| [• Angina (Chest pain)] | [• Emphysema or Chronic Obstructive Pulmonary Disease (COPD)] | [• Peripheral vascular disease] | [• Systemic lupus] |
| [• Arteriosclerosis] | [• Fibromyalgia] | [• Polyneuropathy] | [• Ulcerative colitis] |
| [• Bipolar Disorder] | [• Kidney disorders, excluding kidney stones] | [• Psoriatic arthritis] | [• Any condition that resulted in Bariatric Surgery] |
| [• Cardiomyopathy] | | [• Pulmonary Fibrosis] | |
| [• Coronary artery disease] | | [• Rheumatoid arthritis] | |
- [18.] [Within the last [[1-5] years] [[1-12] months], has the [primary] [proposed] [insured] missed [1-10] consecutive days or [1-10] total days of work because of [their] [your] sickness or injury for which symptoms existed? [Do NOT include routine childbirth.]..... ☐ Yes ☐ No]
- [19.] [Within the last [[1-5] years] [[1-12] months], has the [primary] [proposed] [insured] experienced symptoms, been diagnosed as having or been treated for an injury or disorder to the back, the neck or a joint?..... ☐ Yes ☐ No]
- [20.] [Within the last [[1-5] years] [[1-12] months], has the [primary] [proposed] [insured] received disability benefits or claimed Workers' Compensation?..... ☐ Yes ☐ No]

For Questions 21-32, WITHIN THE LAST [1-10] YEARS, HAS ANY [THE] [PRIMARY] [PROPOSED] [INSURED]:

[Note: any follow-up visits in the last [1-10] years as a result of a diagnosis over [1-10] years ago must be disclosed.]

- [21.] [Had surgery in a hospital or outpatient facility? ☐ Yes ☐ No]

- [22.] [Had medical treatment [in a hospital or outpatient facility] [other than already disclosed]? ☐ Yes ☐ No]
- [23.] [Had any urgent care or emergency room visits [not disclosed in Questions [21] & [22]]? ☐ Yes ☐ No]
- [24.] [Received treatment, testing, consulted with or received a diagnosis from a physician or other healthcare provider [other than already disclosed]? [Do NOT include any physical exams.] ☐ Yes ☐ No]
- [25.] [Had any testing [with abnormal findings] or tests from which you have not received results [other than already disclosed]? ☐ Yes ☐ No]
- [26.] [Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed? ☐ Yes ☐ No]
- [27.] [Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups? ☐ Yes ☐ No]
- [28.] [Used illegal drugs, or prescription medications other than as prescribed, or been advised by a physician or other healthcare provider to discontinue or decrease alcohol consumption or drug use? ☐ Yes ☐ No]

Additional Questions

- [29.] [Has the [primary] [proposed] [insured] [ever] taken or been advised to take any prescription medication [in the last [[1-10] years] [[1-12] months]]? ☐ Yes ☐ No]
[If "Yes," please give complete details below]

| Last | Name First | MI | Name of Medication | Dosage and Frequency of Use | Date Prescribed | Date Last Used | Condition(s) Being Used For |
|------|---------------|----|-----------------------|-----------------------------------|--------------------|----------------|-----------------------------|
| | | | | | | | |
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- [30.] [Has [the] [any] [primary] [proposed] [adult] [insured] [ever] used tobacco products in any form or nicotine substitutes [within the last [[1-10] years] [[1-12] months]] [after the age of [21]]? ☐ Yes ☐ No]
- [31.] [Has [any] [the] [primary] [proposed] [insured]] had a diagnosis, [[or] treatment] [or follow-up] for cancer in the last [1-10] years? ☐ Yes ☐ No]
- [32.] [Is any [the] [primary] [proposed] [insured]] currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy? [This includes a surrogate mother or any person that she is contracted with.] ☐ Yes ☐ No]
- [33.] [Have you fully disclosed all medical conditions for you [and your family] within the last [1-10] years? ☐ Yes ☐ No]

REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE

[34.] [Has there been any medical treatment or medication use for, or have you consulted with a physician or healthcare provider concerning the condition(s) which has had a Condition Specific Deductible, been ridered or rated since the covered person's effective date?..... ☐ Yes ☐ No]]

OTHER PHYSICIANS

[Physician or Healthcare Provider seen in the last [1-10] years [for] [each] [primary] [proposed] [insured] [other than disclosed above]. Attach a separate sheet if additional space is needed. Sign and date any additional sheets.

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____

Person _____ Physician _____ Specialty _____

Address or Phone Number _____

Date Last Seen _____ Reason & Results _____ Follow-up visit: ☐ Yes ☐ No Date _____]

ADDITIONAL MEDICAL DETAILS

Attach a separate sheet if additional space is needed. Sign and date any additional sheets.

| | Last | Name First | MI | Provide Dates, Type of Treatment, Diagnosis or Condition, Results | Full Recovery? | Name of Doctor or Hospital, and Complete Address and Phone Number |
|-------------|------|---------------|----|---|--|---|
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Question #: | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

ADDITIONAL NOTES

[HIPAA ELIGIBILITY

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the below statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

☐ No, I or anyone to be insured do not meet any of the above requirements.

☐ Yes, I or anyone to be insured meet all of the above requirements.]

[EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for [individual] [supplemental] short term disability insurance for you [(and your family)]. [You further understand that this application for [supplemental] short term disability insurance [will] [may] [be] [fully] [medically] [underwritten] [,] [and] [is subject to eligibility requirements] [and that coverage is not guaranteed].] You are personally paying the entire premium for this [supplemental] [short term disability] insurance coverage.

Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

[[If my employer has [2]-[50] full-time employees,] I agree that I will not use [employer contributions] [or] [funds from a [Health Reimbursement Arrangement] [(HRA)] [or a Cafeteria Plan]] to pay the premium for my individual coverage.]

Do you agree with this statement?☐ Yes ☐ No]

AUTHORIZATION

[In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me [or my family] as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.]

[I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) I must call Time Insurance Company and complete the Personal Health History portion of the application process within 10 days of commencement of the application process and subsequently provide any and all medical information related thereto. (2) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the application form information with a signature and returning that signed acceptance to Time Insurance Company. (3) [Except as otherwise provided in the Conditional Receipt,] [T][t]he insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (4) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (5) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.]

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or application determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for application.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of application, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.]

Signature of [Primary] [Proposed] [Insured] _____ Date Signed _____ Time Signed _____^{A.M./P.M.} _____ City _____ State _____

Signature of Spouse[/Domestic Partner] [/Civil Union]
or Other (if proposed to be insured)

Signature(s) of Other Dependent(s) 18 or Over
(if proposed to be insured)

Guardian's Signature

Requested Effective Date: _____ Premium Amount Sent: \$ _____ One-time Processing Fee Sent*: _____]
*Not applicable in all states

[ADDITIONAL NOTICES

[NOTIFICATION REGARDING ("MIB") formerly known as the MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.]

[ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.]

[FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.]

[PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on application forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]]

**SHORT TERM DISABILITY INCOME COVERAGE
OUTLINE OF COVERAGE FOR
POLICY FORM 8034.POL.AR**

THIS POLICY PROVIDES LIMITED BENEFITS

**BENEFITS PROVIDED ARE FOR LOSS OF INCOME AND
DO NOT PROVIDE REIMBURSEMENT OF MEDICAL EXPENSES**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of the policy. This is not the insurance policy and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and [Time Insurance Company]. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

SHORT TERM DISABILITY INCOME COVERAGE: Policies of this category are designed to provide, to the person insured, coverage for disability resulting from a covered injury or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

BENEFITS: The following provisions set forth the benefits which are covered under the policy subject to the conditions and exclusions and limitations set forth herein. The policy provides the policyholder with short term disability income insurance benefits if the policyholder becomes continuously Totally [or Partially] Disabled as a result of [Non-Work Related Sickness or Injury][Injury][,][or] [Sickness] [or pregnancy or childbirth]. Benefits are payable for only one eligible disability period at a time.

| [COVERAGE INFORMATION] |
|--|
| Monthly Benefit: [\$ _____] Elimination Period - Injury: [_____] days Elimination Period - Sickness: [_____] days Maximum Benefit Period: [[4-104] weeks][[30-730]days] per Eligible Disability Period for [Non-Work Related] Sickness or Injury. [[[4-52] weeks][[30-365] days] per Eligible Disability Period for pregnancy. [[4-52] weeks][[30-365] days] per Eligible Disability Period for childbirth. The Maximum Benefit Period for pregnancy or childbirth may be extended to the term of Maximum Benefit Period for [Non-Work Related] Sickness or Injury stated above if You provide proof of continued disability beyond the period for pregnancy or childbirth.] |
| [PREMIUM INFORMATION] |
| Premium Payment Mode: _____ TOTAL MODAL PREMIUM AMOUNT: _____]] |

BENEFITS PROVIDED BY THE POLICY:

Total Disability Benefits

The Monthly Benefit will be paid for an Eligible Disability Period due to the Total Disability from the first day of the Eligible Disability Period following the applicable Elimination Period, as shown on the Benefit Schedule, until the Maximum Benefit Period has been attained or You are no longer Totally Disabled, if earlier. When the Eligible Disability Period occurs during only a portion of a calendar month, the Monthly Benefit due for that period will be prorated according to the days of Total Disability during the Eligible Disability Period occurring that month.

Total Disability Benefits are not payable for any time during the Eligible Disability Period during which You are receiving any wages or compensation for any work, regardless of whether or not it is Your Primary Occupation.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]

[Partial Disability Benefits]

A portion of the Monthly Benefit will be paid for an Eligible Disability Period due to Partial Disability from the first day of the Eligible Disability Period following the applicable Elimination Period, as shown on the Benefit Schedule, until the Maximum Benefit Period has been attained. The available benefit would be payable as a percentage of the Monthly Benefit equal to the percentage of wage loss resulting from the Partial Disability, not to exceed [0-100%] of the Monthly Benefit.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]]

[Disability Benefits Related to Pregnancy or Childbirth]

We will pay benefits under this policy for Total [or Partial] Disability that is related to or caused by pregnancy or childbirth, including complications, only when such Disability commences after the first [10-24] months from the Effective Date. Benefits are limited by the Maximum Benefit Period specifically for pregnancy or childbirth as stated on the Benefit Schedule.] [A condition that has been specifically excluded from coverage will continue to be excluded after [10-24] months of continuous coverage.]]

[Waiver of Premium]

[This Waiver of Premium provision becomes effective only after You have been continuously insured under this policy for [[15-365] days][[2-18] months]. [After such waiting period, i]]n the event You are continuously Totally [or Partially] Disabled for at least 90 calendar days, We will waive [monthly] premium payments due for the remainder of the current Eligible Disability Period up to the Maximum Benefit Period. When Waiver of Premium benefit is being provided, You are required to provide a monthly Health Care Practitioner's statement documenting Your continued Total [or Partial] Disability. Under no circumstances will Waiver of Premium extend beyond the period during which You are Totally [or Partially] Disabled. [We will not waive premium for any disability related to pregnancy or childbirth regardless of the duration of the disability.] [The Waiver of Premium benefit is only available during the course of one Eligible Disability Period every [3-5] years.]]

DEFINITIONS:

[Partial Disability or Partially Disabled]

As a result of the [Sickness or Injury][pregnancy or childbirth][Non-Work Related Sickness or Injury] that caused disability and for which You are under the care of a Health Care Practitioner, Your Primary Occupation Base Wages, that were effective on the day prior to Your becoming disabled, are reduced by up to [0-100%], and You are able to:

1. perform one or more, but not all, of the material and substantial duties of Your Primary Occupation on a Full-Time Basis; or
2. perform all of the material and substantial duties of Your Primary Occupation on a part-time basis.]]

Total Disability/Totally Disabled

You are unable to perform the essential duties of Your Primary Occupation resulting in [total loss of Base Wages income][a reduction of [50-100]% [or more] of Your Base Wages][, due to disability caused by [Sickness or Injury][Non-Work Related Sickness or Injury][[Sickness, Injury,] or pregnancy or childbirth] for which You are under the care of a Health Care Practitioner]. [Retired individuals and homemakers will not be considered unable to perform an occupation solely because they are unemployed.]

PRE-EXISTING CONDITIONS LIMITATION: Benefits will not be paid under the policy for Total [or Partial] Disability that is related to or caused by a Pre-Existing Condition until the Policyholder has been continuously covered under the policy for [12-24] months. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.] [A pregnancy that exists [on the day before][at any time during the [6-24]month period prior to] the Policyholder's Effective Date will be considered a Pre-Existing Condition.]]

EXCLUSIONS AND LIMITATIONS:

Benefits are not payable for losses caused or contributed to by:

1. disability for which Our liability cannot be determined because a Policyholder, Health Care Practitioner, facility, or other individual or entity within 30 days of Our request, failed to:
 - a. Authorize the release of all medical records to Us and other information We requested.
 - b. Provide Us with information We requested about pending claims or other insurance coverage.
 - c. Provide Us with information as required by any contract with Us.
 - d. Provide Us with information that is accurate and complete.
 - e. Have any examination completed as We requested.
 - f. Provide reasonable cooperation to any requests made by Us
- [2.] [disability that is related to or a complication of a Pre-Existing Condition.]
- [3.] [disability caused by [Work-Related] Sickness or Injury[eligible for benefits under worker's compensation, employers' liability or similar laws even when the Policyholder does not file a claim for benefits]. [This exclusion will not apply to any of the following:
 - [a.] [The sole proprietor, if the Policyholder's employer is a proprietorship.]
 - [b.] [A partner of the Policyholder's employer, if the employer is a partnership.]
 - [c.] [An executive officer of the Policyholder's employer, if the Policyholder's employer is a corporation.]
 - [d.] [A Policyholder who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.]]]
- [4.] [disability for which a Policyholder is entitled to loss of income benefits under any motor vehicle medical payment or premises medical expense coverage. Coverage under this policy is secondary to disability income payment or coverage available to the Policyholder, regardless of whether such other coverage is described as secondary, excess or contingent.]
- [5.] [disability caused by or contributed to by:
 - a. War or any act of war, whether declared or undeclared.
 - b. Participation in the military service of any country or international organization, including non-military units supporting such forces.
 - c. Foreign or domestic acts of terrorism[that result in a nationwide epidemic].]
- [6.] [disability caused by or related to the Policyholder's weight or related to obesity or morbid obesity conditions, including treatment thereof.]
- [7.] [disability caused by or related to maternity, pregnancy, or childbirth[when the disability begins less than [270-365] calendar days from the Effective Date or date of reinstatement], except for Complications of Pregnancy.]
- [8.] [disability caused by or related to the following, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual function, and treatments thereof.]
- [9.] [disability caused by or related to treatment, services, supplies or drugs designed or used to diagnose, treat, alter, impact, or differentiate a Policyholder's genetic make-up or genetic predisposition.]
- [10.] [disability caused by or related to: mental illness; anxiety or nervous disorders; being intoxicated or under the influence of any controlled substance, except when taken under the medical advice of a Health Care Practitioner; behavior modification or behavioral (conduct) problems; or learning disabilities. Mental illness and anxiety or nervous disorders include all disorders listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.]
- [11.] [disability caused by or related to an Injury sustained in operating a motor vehicle while the Policyholder is intoxicated and, as defined by law, the Policyholder's blood alcohol level was over the legal limit. This exclusion applies whether or not the Policyholder is charged with any violation in connection with the Accident.]
- [12.] [disability caused by or related to Sickness or Injury of which a contributing cause was the Policyholder's voluntary attempt to commit, participation in or commission of a felony,

misdemeanor, or illegal act.]

[13.] any amount in excess of the Maximum Benefit Period or any other maximum benefit for covered benefits.

[14.] disability caused by or related to Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, including voluntary ingestion, inhalation or injection of poisons, toxins or gaseous substances, even if the Policyholder did not intend to cause the harm which resulted from the action. This exclusion applies regardless of whether the Policyholder was sane or insane at the time the event occurred.

[15.] [disability caused by or related to Injury received while engaging in any hazardous occupation or other activity including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [horse riding] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]

[16.] [disability caused by or related to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [skiing], [horse riding] [, hunting] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]

[17.] disability caused by or related to chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment, and other Cosmetic Services.

[18.] [disability occurring or being treated outside of the United States [or Canada].]

[19.] disability caused by or related to flight in an aircraft other than as a fare-paying passenger on a regularly scheduled flight by an airline.

[20.] disability caused by or related to any organ donation[, within the first 12 months following the Effective Date], sterilization or any other [elective] procedure that is not Medically Necessary.

[21.] [disability caused by or related to any condition, treatment, body part, or system specifically excluded by a Special Exception Rider.]

[22.] [disability caused by or contributed by a complication of a Sickness, Injury, or medical treatment or services that are not covered under this policy.]

RENEWABILITY PROVISION: The policy will remain in force except for any one of the following reasons:

- The date We receive a request in writing or by telephone to terminate this policy or on a later date that is requested by the Policyholder for termination
- The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
- The date of death of the Policyholder. In the event of the death of the Policyholder, You will be entitled to a refund of all unearned premiums.
- [The date there is fraud made by or with the knowledge of any Policyholder filing a claim for benefits.]
- [The date the Policyholder moves to a state where We do not provide insurance coverage.]
- [The date the Policyholder attains age [65-75] years.][The anniversary date of this policy following the Policyholder's [65th – 75th] birthday.] [We may renew Your policy beyond this date if You provide Us with acceptable proof of continued employment beyond such date.]

PREMIUM: The first page shows the total premium for the coverage that was selected. [Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic

area, [gender,] age, plan design, [smoking status,] and change in occupation. All premium adjustments will be made to individuals on the basis of shared characteristics. The mode of payment (monthly, quarterly or other) is subject to change, You will be notified at least 60 days in advance of any such change.]

[RIDERS]

[The following Rider[s] [is]/[are] available with Short Term Disability Income Policy 8034.POL.AR.]

Licensed Agent's Signature

Date

SERFF Tracking Number: MCHX-126379228 State: Arkansas

Filing Company: Time Insurance Company State Tracking Number: 44033

Company Tracking Number: 8034.POL.AR

TOI: H111 Individual Health - Disability Income Sub-TOI: H111.002 Short Term - Unrelated to marketing with employer or association groups

Product Name: 8034.POL.XX Individual Short Term Disability Inco

Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company

Supporting Document Schedules

| | Item Status: | Status Date: |
|--|-----------------|--------------|
| Satisfied - Item: Flesch Certification Comments: Attachments: AR - READABILITY CERTIFICATION.PDF AR Cert of Compliance with Rule 19.PDF Certificate of Compliance R&R 49.PDF | Approved-Closed | 11/19/2009 |
| Satisfied - Item: Application Comments: Please see forms tab | Approved-Closed | 11/19/2009 |
| Satisfied - Item: Outline of Coverage Comments: Please see forms tab | Approved-Closed | 11/19/2009 |
| Satisfied - Item: Forms Listing Comments: Attachment: Forms Listing.PDF | Approved-Closed | 11/19/2009 |
| | Item Status: | Status Date: |

SERFF Tracking Number: MCHX-126379228 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 44033
 Company Tracking Number: 8034.POL.AR
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.002 Short Term - Unrelated to marketing with employer or association groups

Product Name: 8034.POL.XX Individual Short Term Disability Inco
 Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company

Satisfied - Item: 11.10.09 Submission Letter Approved-Closed 11/19/2009
Comments:
Attachment:
 11_10_09 Submission Letter.PDF

Item Status: **Status**
Date:
Satisfied - Item: Statement of Variability Approved-Closed 11/19/2009
Comments:
Attachment:
 Statement of Variability.PDF

Item Status: **Status**
Date:
Satisfied - Item: Authorization Letter Approved-Closed 11/19/2009
Comments:
Attachment:
 Authorization Letter.PDF

Item Status: **Status**
Date:
Satisfied - Item: 11.18.09 Resubmission Letter Approved-Closed 11/19/2009
Comments:
Attachment:
 11_18_09 Resubmission Letter.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION


COMPANY NAME: Time Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

| Form Number | Score |
|----------------------|-------|
| 8034.POL.AR | 56 |
| 8034.TOC.XX | 56 |
| 8034.DEF.AR | 56 |
| 8034.EFF.XX | 56 |
| 8034.STD.AR | 56 |
| 8034.EXC.AR | 56 |
| 8034.CLM.AR | 56 |
| 8034.PRM.AR | 56 |
| 8034.REC.XX | 56 |
| 8034.OTH.AR | 56 |
| 8034.BNS.XX | 52.3 |
| Form 30054 (10/2009) | 62 |
| Form 30044 (10/2009) | 54 |
| Form 30064 (10/2009) | 54 |
| Form 30043 (10/2009) | 72 |
| 8034.OOC.AR | 50.5 |

STATE OF ARKANSAS
READABILITY CERTIFICATION

| Form Number | Score |
|-------------|-------|
|-------------|-------|

Signed: 

Name: Julia Hix-Royer

Title: Vice President, Product Compliance

Date: November 10, 2009

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Time Insurance Company

Form Number(s): 8034.POL.AR, 8034.TOC.XX, 8034.DEF.AR, 8034.EFF.XX,
8034.STD.AR, 8034.EXC.AR, 8034.CLM.AR, 8034.PRM.AR
8034.REC.XX, 8034.OTH.AR, 8034.BNS.XX, Form 30054 (10/2009),
Form 30044 (10/2009), Form 30064 (10/2009), Form 30043 (10/2009)
8034.OOC.AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Julia Hix-Royer

Name

Vice President, Product Compliance

Title

November 10, 2009

Date


CERTIFICATE OF COMPLIANCE

Insurer: Time Insurance Company

Form Numbers: 8034.POL.AR, 8034.TOC.XX, 8034.DEF.AR,

8034.EFF.XX, 8034.STD.AR, 8034.EXC.AR, 8034.CLM.AR, 8034.PRM.AR
8034.REC.XX, 8034.OTH.AR, 8034.BNS.XX, Form 30054 (10/2009),
Form 30044 (10/2009), Form 30064 (10/2009), Form 30043 (10/2009)
8034.OOC.AR

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



Signature of Company Officer

Julia Hix-Royer

Name

Vice President, Product Compliance

Title

November 10, 2009

Date

Short Term Disability Income Insurance
Forms Listing

| <u>Form Number</u> | <u>Form Description</u> |
|---------------------------|--|
| 8034.POL.AR | Short Term Disability Income Policy |
| 8034.TOC.XX | Matrix Insert Section: Table of Contents |
| 8034.DEF.AR | Matrix Insert Section: Definitions |
| 8034.EFF.XX | Matrix Insert Section: Effective Date and Termination Date |
| 8034.STD.AR | Matrix Insert Section: Short Term Disability Income Insurance Benefits |
| 8034.EXC.AR | Matrix Insert Section: Exclusions and Limitations |
| 8034.CLM.AR | Matrix Insert Section: Claim Provisions |
| 8034.PRM.AR | Matrix Insert Section: Premium Provisions |
| 8034.REC.XX | Matrix Insert Section: Recovery Provisions |
| 8034.OTH.AR | Matrix Insert Section: Other Provisions |
| 8034.BNS.XX | Benefit Schedule – Short Term Disability Income Insurance |
| Form 30054 (10/2009) | Acceptance of Offer and Attestation |
| Form 30044 (10/2009) | Application Form for Short-Term Disability Insurance |
| Form 30064 (10/2009) | Tele-App Part 1 Application |
| Form 30043 (10/2009) | Tele-App Part 2 Application |
| 8034.OOC.AR | Outline of Coverage |

McHugh Consulting Resources, Inc.

November 9, 2009

Jay Bradford
Insurance Commissioner
Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third Street
Little Rock, AR 72201-1904

Sent via SERFF

RE: Time Insurance Company
NAIC # 69477 FEIN # 39-0658730

Individual Short Term Disability Policy
8034.POL.AR, et al - Policy
See Attached Form Listing

Actuarial Memorandum - Enclosed

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

We are submitting the above captioned forms and rates for your review and approval. The forms are new and not intended to replace any other forms currently in use.

This Short Term Disability program will be marketed to individuals through agent/broker solicitation. This plan will be offered using the applications herewith submitted or as an integrated offer with other plans using previously filed application or enrollment forms. This program has been Filed For Use in the domicile state of Wisconsin effective November 3, 2009.

This program provides short term disability benefits for loss of income of the policyholder when employed on a full-time basis. It also provides for the following optional disability income benefits: not-at-work disability benefits, partial disability benefits, and disability benefits related to pregnancy or childbirth.

Please note that the Policy is numbered using a matrix format, where each section of the document has a unique form number. For example, the Policy face page is numbered 8034.POL.AR while the Exclusions section of the same document is numbered 8034.EXC.AR. The Company employs this form numbered style for administrative and tracking purposes. The Policy will always be issued in their entirety with all sections and form numbers included.

Acceptance of Offer and Attestation form 30054 (10/2009) enclosed herewith is filed for general use purposes and may be used with other insurance products offered by Time Insurance Company, once approved.

These forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Variable data or text is bracketed and a variability statement is enclosed herewith. Variable data will never exclude provisions required by applicable law.

Attached please find any required certifications and/or transmittal forms and filing fees. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

Sincerely,

A handwritten signature in cursive script, appearing to read "M. Diane Davis".

M. Diane Davis, FLMI
Consultant

Statement of Variability

- All numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.
- Paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.
- Definitions may vary to the extent that such definition may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.
- Items which customarily vary according to the policyholder's specific plan of insurance.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval and amend the language to clarify the intent within the confines of the law.



ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

January 2009

Re: Time Insurance Company-NAIC 69477; FEIN 39-0658730

Dear Sir or Madam,

This letter acts as authorization for McHugh Consulting Resources and its representative analysts to file any or all policy forms as referenced on the attached form listing on behalf of the above referenced company and to serve as the primary contact on behalf of the company regarding such filings while under review. Please contact McHugh Consulting Resources with questions or comments regarding the enclosed filing.

Best Regards,

Daniel Ziebell, MHP
Director Product Compliance
Worksite, Voluntary and Ancillary Products
daniel.ziebell@assurant.com
T 414.299.6045
F 414.299.6168

.....

McHugh Consulting Resources, Inc.

November 18, 2009

Rosalind Minor
Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third Street
Little Rock, AR 72201-1904RE:

Sent via SERFF

**Re: Resubmission
Time Insurance Company
NAIC # 69477 FEIN # 39-0658730
8034.POL.AL et al - Individual Short Term Disability Policy
SERFF Tracking No: MCHX-126379228
Objection Number: 125553233
State Assigned No.: 44033**

Dear Ms. Minor:

This is in response to your objection dated November 16, 2009.

To comply with 23-85-134, item 3. in Termination Date of Coverage on page 8, has been revised to include the following wording:

"In the event of the death of the Policyholder, You will be entitled to a refund of all unearned premiums."

A corresponding change has been made to the Outline of Coverage.

Enclosed are the following revised forms:

8034.POL.AR et al. – Short Term Disability Income Policy
8034.OOC.AR - Outline of Coverage

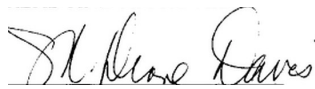
At this time, we respectfully request that the Actuarial Memorandum, currently with your Department be replaced with the attached revised Actuarial Memorandum v4. The actuarial memorandum statement regarding underwriting has been changed from "*The application uses accept/reject underwriting questions*" to read "*The application uses medical underwriting*". This is consistent with the applications filed for review and the Company's underwriting practice.

We trust that we have satisfactorily addressed the Department's concerns and we look forward to obtaining the Department's approval.

Commissioner of Insurance
Time Insurance Company
Page 2 of 2

Please do not hesitate to contact the undersigned at (215) 230-7960 if you have any questions I can answer regarding this filing.

Sincerely,

A handwritten signature in cursive script, appearing to read "M. Diane Davis".

M. Diane Davis, FLMI
Consultant

SERFF Tracking Number: MCHX-126379228 **State:** Arkansas
Filing Company: Time Insurance Company **State Tracking Number:** 44033
Company Tracking Number: 8034.POL.AR
TOI: H111 Individual Health - Disability Income **Sub-TOI:** H111.002 Short Term - Unrelated to marketing with employer or association groups
Product Name: 8034.POL.XX Individual Short Term Disability Inco
Project Name/Number: 8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company/8034.POL.XX Individual Short Term Disability Income Policy - Time Insurance Company

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date: | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s) |
|-----------------------|-----------------|---|----------------------------------|---------------------------------|
| 11/18/2009 | Form | Short Term Disability Income Policy | 01/11/2010 | 8034_POL_AR.PDF (Superceded) |
| 11/11/2009 | Form | Short Term Disability Income Policy-Effective Date and Termination Date | 01/11/2010 | |
| 11/11/2009 | Form | Short Term Disability Income Policy | 11/18/2009 | 8034_POL_AR.PDF (Superceded) |
| 11/11/2009 | Form | Outline of Coverage | 11/18/2009 | 8034_OOC_AR.PDF (Superceded) |

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

SHORT TERM DISABILITY INCOME INSURANCE POLICY

The insurance described in this Policy is effective on the date shown in the Benefit Schedule only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan.

This policy describes the benefits and major provisions which affect the Policyholder. The Policy is issued in the State of [Arkansas] and is governed by applicable laws of that State and federal laws, except as otherwise provided by this Policy.

This policy is issued based on the statements and agreements in the application form, any exam that may be required, any other amendments or supplements and the payment of the required premium. This policy and premium cost may be changed. [If that happens, You will be notified of any such changes].

Please read Your policy carefully and become familiar with its terms, limits and conditions.

RIGHT TO EXAMINE POLICY FOR [10-30] DAYS

If You are not satisfied, return the policy to Us or Our agent within [10-30] days after You have received it. All premiums will be refunded and Your coverage will be void.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION FORM FOR INSURANCE

Please read the copy of the application form included with this policy. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the application form. If a material omission or misstatement is made in the application form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount. Carefully check the application form and, if any information shown in the application form is not correct and complete, write to Us at the address above, within [10-30] days.

[insert secretary signature]
Secretary

[insert president signature]
President

[This policy is guaranteed renewable until age [65-75] years.] [This policy contains a Pre-Existing Conditions Limitation.]

NOTICE: This policy insures for loss of income of the Policyholder when employed on a Full-Time Basis. This plan does not pay benefits when income [from Your Primary Occupation] does not exist prior to the date of disability[, except as provided by the Not-At-Work Disability Benefit]. Read Your policy carefully.

GUIDE TO YOUR POLICY

The sections of the policy appear in the following order:

- I. Definitions
- II. Effective Date and Termination Date
- III. Benefits
- IV. Exclusions and Limitations
- V. Claim Provisions
- VI. Premium Provisions
- VII. Recovery Provisions
- VIII. Other Provisions

I. DEFINITIONS

When reading this policy, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this policy are defined below. Just because a term is defined does not mean it is covered. Please read the policy carefully.

Accident or Accidental

Any unexpected event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.
2. It results from a trauma.
3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.
4. It is definite as to time and place.
5. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness or a cerebrovascular accident. Accident does not include any overdose of controlled substance, drug, or narcotic except when taken under the medical advice of a Health Care Practitioner.

Base Wages

The basic gross wage or salary paid as compensation to You for work performed on a Full-Time Basis, but not including overtime pay, bonuses, commissions, or any other special compensation not received as basic wages or salary. [If You are paid on an hourly basis, Base Wages will be based on the hourly rate of pay. No more than [40] hours per week will be considered in determining Base Wages for hourly workers.] Base Wages for self-employed individuals will be calculated by subtracting allowable business deduction amounts from the business's gross income.

Calendar Year

The period beginning on January 1 of any year and ending on December 31 of the same year.

Complications of Pregnancy

Complications of Pregnancy include the following:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, severe preeclampsia and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. Non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Cosmetic Services

A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or relieve or prevent social, emotional or psychological distress.

Effective Date

The date coverage under this plan begins for a Policyholder as stated on the Benefit Schedule. The Policyholder's coverage begins at 12:01 a.m. local time at the Policyholder's state of residence.

Eligible Disability Period

Eligible Disability Period means each separate period of Total [or Partial] Disability. However, a later period of Total [or Partial] Disability will be considered to be a continuation of the earlier "Eligible Disability Period" if it starts while the Policyholder is insured under this coverage and,

1. if the later period of Total [or Partial] Disability is due to the same or related causes as the earlier period of Total [or Partial] Disability, and it is separated by a return to work on a Full-Time Basis for less than [10-360][business days][calendar days], or
2. if the later period of Total [or Partial] Disability is due to causes not related to the earlier period of Total [or Partial] Disability, and it is separated by a return to work on a Full-Time Basis for less than [1-90][business day[s]][calendar day[s]].

The applicable Elimination Period and the Maximum Benefit Period shown on the Benefit Schedule apply to each Eligible Disability Period separately.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90][calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]

Elimination Period

The period of consecutive days that must pass after the beginning of a period of Total [or Partial] Disability before a Policyholder is eligible for specific benefits as shown in the Benefit Schedule under the terms of this plan. No benefits are payable during the Elimination Period. The Elimination Period applies separately to each Maximum Benefit Period.

An Elimination Period will vary depending on if the Total [or Partial] Disability is due to a [Non-Work Related] Sickness or Injury [or pregnancy or childbirth]. The Benefit Schedule will identify the applicable Elimination Periods.

Full-Time Basis

Working or scheduled to work at a job at least [30-40] hours per week for at least [35-50] weeks per Calendar Year for Base Wages.

Health Care Practitioner

A person licensed by the state or other geographic area in which the medical services are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Home Office

Our office in [Milwaukee, Wisconsin] or other administrative offices as indicated by Us.

Immediate Family Member

An Immediate Family Member is:

1. You or Your spouse or
2. The children, brothers, sisters and parents of either You or Your spouse; or
3. The spouses of the children, brothers and sisters of You and Your spouse or
4. Anyone with whom a Policyholder has a relationship based on a legal guardianship.

Injury

Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

Maximum Benefit Period

The maximum time period per Eligible Disability Period for which benefits under this policy are payable following the applicable Elimination Period. [The Maximum Benefit Period is different depending on if the Total [or Partial] Disability is caused by [Non-Work Related Sickness or Injury] [Sickness, Injury,] [or] [pregnancy, or childbirth.] The applicable Maximum Benefit Period is stated on Your Benefit Schedule.

Medically Necessary or Medical Necessity

Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Policyholder's Immediate Family Member. We must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and
2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and
3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and
4. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.

Monthly Benefit

The amount of Monthly Benefit as shown on Your Benefit Schedule.

[Non-Work Related Sickness or Injury

Accidental Injury or Sickness occurring independent of any employment related activity.]

Partial Disability or Partially Disabled

As a result of the [Sickness or Injury][pregnancy or childbirth][Non-Work Related Sickness or Injury] that caused disability and for which You are under the care of a Health Care Practitioner, Your Primary Occupation Base Wages, that were effective on the day prior to Your becoming disabled, are reduced by up to [0-100%], and You are able to:

1. perform one or more, but not all, of the material and substantial duties of Your Primary Occupation on a Full-Time Basis; or
2. perform all of the material and substantial duties of Your Primary Occupation on a part-time basis.

Policyholder

The person to whom the policy is issued as shown in the Benefit Schedule.

Pre-Existing Condition

A Sickness or an Injury and related complications:

1. For which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed during the [6-24]-month period immediately prior to the Policyholder's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
2. That produced signs or symptoms during the [6-24]-month period immediately prior to the Policyholder's Effective Date.

The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

- a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
- b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

[A pregnancy that exists [on the day before][at anytime during the [6-24] month period prior to] the Policyholder's Effective Date will be considered a Pre-Existing Condition.]

Primary Occupation

Your Primary Occupation is the employment activity You engage in on a Full-Time Basis. In the event You are concurrently engaged in a more than one employment activity on a Full-Time Basis, Your Primary Occupation will be considered the employment providing the highest Base Wages.

Recurrent Disability

A period of Total [or Partial] Disability occurring at least [30-90] [calendar][business] days after the termination of a previous period of Total [or Partial] Disability which was a covered Eligible Disability Period under this policy and is not considered a continuation of that prior Eligible Disability Period as defined in this policy.

Sickness

A disease or illness of a Policyholder. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness. Sickness includes Complications of Pregnancy[, but not the pregnancy itself].]

Single Plan

A plan of insurance covering only the Policyholder.

[Special Exception Rider

A form that is included with this plan which identifies a body part, system, disease, Sickness, Injury or other condition for a Policyholder in which all charges related to that body part, system, disease, Sickness, Injury or other condition are excluded from coverage for a specified period of time as shown in the Special Exception Rider.]

Total Disability/Totally Disabled

You are unable to perform the essential duties of Your Primary Occupation resulting in [total loss of Base Wages income][a reduction of [50-100]% [or more] of Your Base Wages][, due to disability caused by [Sickness or Injury][Non-Work Related Sickness or Injury][[Sickness, Injury,] or pregnancy or childbirth] for which You are under the care of a Health Care Practitioner]. [Retired individuals and homemakers will not be considered unable to perform an occupation solely because they are unemployed.]

We, Us, Our, Our Company

Time Insurance Company or its administrator.

[Work Related Sickness or Injury

Accidental Injury or Sickness occurring during or arising out of any employment activity.]

You, Your, Yours

The person listed on the Benefit Schedule as the Policyholder.

II. EFFECTIVE DATE AND TERMINATION DATE

Eligibility and Effective Date of Policyholder

A person who is eligible may elect to be covered under this plan by completing and signing an application form and submitting any required premium. [You must be a resident of or employed in Your Primary Occupation in the state where this policy is issued on the Effective Date.]

Evidence of insurability must also be provided. Your coverage will take effect at 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

[This is a Single Plan only.]

[The rates may change for reasons including but not limited to if the Policyholder moves to another zip code or there is a change in benefits or class.]

Termination Date of Coverage

The Policyholder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid in accordance with the laws of the state in which the policy is issued minus any claims that were incurred after the termination date and paid by Us.

This policy will terminate at 12:01 a.m. local time in the state of issue on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this policy or on a later date that is requested by the Policyholder for termination
2. The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
3. The date of death of the Policyholder. In the event of the death of the Policyholder, You will be entitled to a refund of all unearned premiums.
4. [The date there is fraud made by or with the knowledge of any Policyholder filing a claim for benefits.]

[5.] [The date the Policyholder moves to a state where We do not provide insurance coverage.]

[6.] [The date the Policyholder attains age [65-75] years.][The anniversary date of this policy following the Policyholder's [65th – 75th] birthday.]

III. SHORT TERM DISABILITY INCOME INSURANCE BENEFITS

WE WILL PAY BENEFITS ONLY AS PROVIDED IN THIS POLICY, INCLUDING THE BENEFIT SCHEDULE AND ANY RIDERS OR ENDORSEMENTS HERETO. THE MAXIMUM BENEFIT LIMITATION IS SHOWN ON THE BENEFIT SCHEDULE.

REFER TO THE EXCLUSIONS AND LIMITATIONS SECTION OF THE POLICY FOR DISABILITY THAT IS NOT COVERED UNDER THIS POLICY.

We will not pay benefits for disability during a Policyholder's Elimination Period as shown in the Benefit Schedule.

If the Policyholder, while insured under this policy subject to the Effective Date and Termination Date section of this policy, becomes continuously Totally [or Partially] Disabled as a result of [Non-Work Related Sickness or Injury][Injury][.][or] [Sickness] [or pregnancy or childbirth], We will pay Short Term Disability Income Insurance Benefits subject to the provisions below, Exclusions and Limitations provisions and all the terms and conditions of this policy.

Benefits are payable for only one Eligible Disability Period at a time, even if Total [or Partial] Disability is caused by concurrent [Non-Work Related Sickness or Injury] [Sickness or Injury][.][or pregnancy or childbirth]. If You have other short term disability income coverage under another plan with Us or one of Our affiliated companies, We will pay only the plan benefits providing the greatest [total] benefit amount per eligible disability.

Total Disability Benefits

The Monthly Benefit will be paid for an Eligible Disability Period due to the Total Disability from the first day of the Eligible Disability Period following the applicable Elimination Period, as shown on the Benefit Schedule, until the Maximum Benefit Period has been attained or You are no longer Totally Disabled, if earlier. When the Eligible Disability Period occurs during only a portion of a calendar month, the Monthly Benefit due for that period will be prorated according to the days of Total Disability during the Eligible Disability Period occurring that month.

Total Disability Benefits are not payable for any time during the Eligible Disability Period during which You are receiving any wages or compensation for any work, regardless of whether or not it is Your Primary Occupation.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]

[Partial Disability Benefits

A portion of the Monthly Benefit will be paid for an Eligible Disability Period due to Partial Disability from the first day of the Eligible Disability Period following the applicable Elimination Period, as shown on the Benefit Schedule, until the Maximum Benefit Period has been attained. The available benefit would be payable as a percentage of the Monthly Benefit equal to the

percentage of wage loss resulting from the Partial Disability, not to exceed [0-100%] of the Monthly Benefit.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]]

[Disability Benefits Related to Pregnancy or Childbirth

We will pay benefits under this policy for Total [or Partial] Disability that is related to or caused by pregnancy or childbirth, including complications, only when such Disability commences after the first [10-24] months from the Effective Date. Benefits are limited by the Maximum Benefit Period specifically for pregnancy or childbirth as stated on the Benefit Schedule.] [A condition that has been specifically excluded from coverage will continue to be excluded after [10-24] months of continuous coverage.]]

[Waiver of Premium

[This Waiver of Premium provision becomes effective only after You have been continuously insured under this policy for [[15-365] days][[2-18] months]. [After such waiting period, i][l]n the event You are continuously Totally [or Partially] Disabled for at least 90 calendar days, We will waive [monthly] premium payments due for the remainder of the current Eligible Disability Period up to the Maximum Benefit Period. When Waiver of Premium benefit is being provided, You are required to provide a monthly Health Care Practitioner's statement documenting Your continued Total [or Partial] Disability. Under no circumstances will Waiver of Premium extend beyond the period during which You are Totally [or Partially] Disabled. [We will not waive premium for any disability related to pregnancy or childbirth regardless of the duration of the disability.] [The Waiver of Premium benefit is only available during the course of one Eligible Disability Period every [3-5] years.]]

IV. EXCLUSIONS AND LIMITATIONS

[Pre-Existing Conditions Limitation

We will not pay benefits under this policy for Total [or Partial] Disability that is related to or caused by a Pre-Existing Condition until the Policyholder has been continuously covered under this policy for [12-24] months. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.] [A pregnancy that exists [on the day before][at any time during the [6-24]month period prior to] the Policyholder's Effective Date will be considered a Pre-Existing Condition.]]

[Sickness Limitation on New Policy

We will not pay benefits under this policy for Total [or Partial] Disability that is related to or caused by a Sickness that manifests itself or is diagnosed or treated within the first 30 days from the Effective Date until the Policyholder has been continuously covered under this policy for [12-24] months. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.]]

General Exclusions

We will not pay benefits for Total Disability [or Partial Disability] caused, whether in whole or in part, by any of the following:

1. disability for which Our liability cannot be determined because a Policyholder, Health Care Practitioner, facility, or other individual or entity within 30 calendar days of Our request, failed to:
 - a. Authorize the release of all medical records to Us and other information We requested.
 - b. Provide Us with information We requested about pending claims or other insurance coverage.
 - c. Provide Us with information as required by any contract with Us.
 - d. Provide Us with information that is accurate and complete.
 - e. Have any examination completed as We requested.
 - f. Provide reasonable cooperation to any requests made by Us

Upon receipt of information allowing the determination of Our liability, We will reopen any claim for benefits. No claim for benefits can be reopened after [180-540] [calendar][business] days.

- [2.] [disability that is related to or a complication of a Pre-Existing Condition.]
- [3.] [disability caused by [Work-Related] Sickness or Injury[eligible for benefits under worker's compensation, employers' liability or similar laws even when the Policyholder does not file a claim for benefits]. [This exclusion will not apply to any of the following:
 - [a.] [The sole proprietor, if the Policyholder's employer is a proprietorship.]
 - [b.] [A partner of the Policyholder's employer, if the employer is a partnership.]

- [c.] [An executive officer of the Policyholder's employer, if the Policyholder's employer is a corporation.]
- [d.] [A Policyholder who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.]]]
- [4.] [disability for which a Policyholder is entitled to loss of income benefits under any motor vehicle medical payment or premises medical expense coverage. Coverage under this policy is secondary to disability income payment or coverage available to the Policyholder, regardless of whether such other coverage is described as secondary, excess or contingent.]
- [5.] [disability caused by or contributed to by:
 - a. War or any act of war, whether declared or undeclared.
 - b. Participation in the military service of any country or international organization, including non-military units supporting such forces.
 - c. Foreign or domestic acts of terrorism[that result in a nationwide epidemic].]]
- [6.] [disability caused by or related to the Policyholder's weight or related to obesity or morbid obesity conditions, including treatment thereof.]
- [7.] [disability caused by or related to maternity, pregnancy, or childbirth[when the disability begins less than [270-365] calendar days from the Effective Date or date of reinstatement], except for Complications of Pregnancy.]
- [8.] [disability caused by or related to the following, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual function, and treatments thereof.]
- [9.] [disability caused by or related to treatment, services, supplies or drugs designed or used to diagnose, treat, alter, impact, or differentiate a Policyholder's genetic make-up or genetic predisposition.]
- [10.] [disability caused by or related to: [mental illness; anxiety or nervous disorders;] [being intoxicated or under the influence of any controlled substance, except when taken under the medical advice of a Health Care Practitioner;] [behavior modification or behavioral (conduct) problems;] or [learning disabilities]. [Mental illness and anxiety or nervous disorders include all disorders listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.]]
- [11.] [disability caused by or related to an Injury sustained in operating a motor vehicle while the Policyholder is intoxicated and, as defined by law, the Policyholder's blood alcohol level was over the legal limit. This exclusion applies whether or not the Policyholder is charged with any violation in connection with the Accident.]

- [12.] [disability caused by or related to Sickness or Injury of which a contributing cause was the Policyholder's voluntary attempt to commit, participation in or commission of a felony, misdemeanor, or illegal act.]
- [13.] any amount in excess of the Maximum Benefit Period or any other maximum benefit for covered benefits.
- [14.] disability caused by or related to Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, including voluntary ingestion, inhalation or injection of poisons, toxins or gaseous substances, even if the Policyholder did not intend to cause the harm which resulted from the action. This exclusion applies regardless of whether the Policyholder was sane or insane at the time the event occurred.
- [15.] [disability caused by or related to Injury received while engaging in any hazardous occupation or other activity including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [horse riding] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]
- [16.] [disability caused by or related to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [skiing], [horse riding] [, hunting] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]
- [17.] disability caused by or related to chemical peels, reconstructive or cosmetic/plastic surgery that does not alleviate a functional impairment, and other Cosmetic Services.
- [18.] [disability occurring or being treated outside of the United States [or Canada].]
- [19.] disability caused by or related to flight in an aircraft other than as a fare-paying passenger on a regularly scheduled flight by an airline.
- [20.] disability caused by or related to any organ donation[, within the first 12 months following the Effective Date], sterilization or any other [elective] procedure that is not Medically Necessary.

[21.][disability caused by or related to any condition, treatment, body part, or system specifically excluded by a Special Exception Rider.]

[22.] [disability caused by or contributed by a complication of a Sickness, Injury, or medical treatment or services that are not covered under this policy.]

V. CLAIM PROVISIONS

Notice of Claim

You must notify Us of the claim within [20-90] [calendar][business] days after the start of an Eligible Disability Period, or as soon as reasonably possible[, by calling Our Home Office]. When providing notice of claim, You must include Your name, address, and policy number. .

Claim Forms

Within [15-30] [calendar][business] days after We receive Your notice of claim, We will provide claim forms to be used when submitting Proof of Loss. The forms must be completed and sent to Us or Our designee. If You do not receive the claim forms within [15-30] [calendar][business] days, we will accept a written description of the exact nature and extent of the loss as Proof of Loss provided it meets the requirements, including timeframes, for submitting Proof of Loss stated below.

Proof of Loss

We must receive written or electronic proof of loss for Total [or Partial] Disability due to a [Non-Work Related]Sickness or an Injury [or pregnancy or childbirth]for which the claim is made. Proof of loss must be provided to Us within [90-180] calendar days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date the [Eligible Disability Period or Maximum Benefit Period ends, whichever is later,][Proof of Loss is otherwise required,] unless You are declared incompetent by a court of law.

The proof of loss must include all of the following:

- 1) Your name, address and policy number.
- 2) Verification of Your income and occupation.
- 3) The details and supporting medical documentation of the loss for which claim is made.

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us.

Right to Collect Information

To determine Our liability, We may request additional information from a Policyholder, Health Care Practitioner, facility, or other individual or entity. A Policyholder must cooperate with Us, and assist Us by obtaining the following information within [30-90][calendar][business] days of Our request. Benefits will be denied if We are unable to determine Our liability because a Policyholder, Health Care Practitioner, facility, or other individual or entity failed to:

1. Authorize the release of all medical records to Us and other information We requested.
2. Provide Us with information We requested about pending claims or other insurance coverage.
3. Provide Us with information as required by any contract with Us.
4. Provide Us with information that is accurate and complete.

5. Have any examination completed as requested by Us.
6. Provide reasonable cooperation to any requests made by Us.

Upon receipt of information allowing the determination of Our liability, We will reopen any claim for benefits. No claim for benefits can be reopened after [180-540] [calendar][business] days.

Physical Examination Medical Review and Autopsy

We have the right to have a Health Care Practitioner of Our choice conduct a review of medical records and/or examine a Policyholder at any time regarding a claim for benefits or to verify any claim of Total [or Partial] Disability. Health Care Practitioner charges for these reviews and/or exams will be paid by Us. We also have the right, in case of death, to have an autopsy done, at Our expense, where it is not prohibited by law.

Payment of Benefits

When We receive due written proof of the disability and determine Our liability, benefits will be paid to the Policyholder [once a week][every 2 weeks][at least once per month], but will be determined by the actual number of calendar days You are Totally Disabled [or Partially Disabled] in accordance with the Short Term Disability Income Insurance Benefits section. Any benefits unpaid at Your death will be paid at Our option to Your spouse, Your estate or the providers of the services. Benefits may not be assigned.

Any amount We pay will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for coverage of a Sickness or an Injury. It also does not constitute any assumption of liability for further coverage. Any benefit paid in error may be recovered from You or the person or entity receiving the incorrect payment. We may offset the overpayment against future benefit payments.

Rights of Administration

We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.

Claims Involving Fraud or Misrepresentation

Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Policyholder or a Policyholder's representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved fraud or misrepresentation, We will be entitled to a refund from You, the Beneficiary or the person receiving the payment.

If the Policyholder, or anyone acting on the Policyholder's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Policyholder may be subject to civil and/or criminal penalties.

Claim Appeal

You have the right to request a review of all adverse claim decisions. A review must be requested by writing to Us at Our Home Office within 180 [calendar][business] days following Your receipt of the notice that the claim was denied or reduced.

VI. PREMIUM PROVISIONS

Consideration

This plan is issued based on the statements and agreements in the Policyholder's application form, any exam of a Policyholder that is required, any other amendment or supplements to the application form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

Premium Payment

The initial premium must be paid [on or before the Effective Date for this coverage to be in force. Subsequent premiums are due] as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received [by] [Us][or][Our designee][in cash or check][or][by credit card or automatic charge to a bank account][at Our office] on [or before] the date due. [We may agree to accept premium payment in alternative forms[, such as credit card or automatic charge to a bank account].] If We tried to obtain payment for the amount due but were unsuccessful, We reserve the right to require an alternative form of payment during the grace period.

[Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] age, plan design, [smoking status,] and change in occupation. All premium adjustments will be made to individuals on the basis of shared characteristics. The mode of payment (monthly, quarterly or other) is subject to change, You will be notified at least 60 days in advance of any such change.]

Grace Period

There is a grace period of 31 calendar days for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the grace period ends.

Coverage will continue during the grace period unless You call Our office or give Us written notice to cancel the coverage. If a claim is payable during the grace period, any unpaid premiums due will be deducted from the claim payment.

[Suspension of Premium

If[, after the Effective Date,] You cease to be employed[on a Full-Time Basis][, due to [involuntary][or][voluntary]loss of employment,] We will suspend Your premium payments for the period of time You are not employed[on a Full-Time Basis], up to [60-365] calendar days. You must notify Us, in writing [or by calling Our Home Office,] when You cease working on a Full-Time Basis in order to suspend Your premium payments. Benefits are not payable during the period that You are not working on a Full-Time Basis. You must notify Us, in writing [or by calling Our Home Office,] when you resume employment on a Full-Time Basis to have Your coverage reinstated.]

Reinstatement

If any premium is not paid within the required time period, coverage for You will lapse. The coverage will be reinstated if all of the following requirements are met:

1. The lapse was not more than [30-365] calendar days.
2. You submit a supplemental application form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us.
3. We approve Your application form for reinstatement.

The coverage will be reinstated on the date We approve Your application form for reinstatement, but no later than 45 days after receipt of the reinstatement application, unless We have provided written notice of disapproval to You.. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

If the coverage is reinstated, the policy is subject to a new Pre-Existing Condition period that begins on the date that We approve Your application form for reinstatement.

A reinstated policy will only cover loss resulting from a[n] [Non-Work Related]Injury if it is sustained after the date of reinstatement. Loss resulting from [Non-Work Related]Sickness [or pregnancy] will be covered only for disability commencing after 10 days following the date of reinstatement. No benefits will be paid for any such condition and related complications if prior to the reinstatement date:

1. Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed regardless of whether the condition was diagnosed or not diagnosed; or
2. The condition produced signs or symptoms that were significant enough to establish manifestation or onset by one of the following tests:
 - a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
 - b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

[A pregnancy that exists on the day before the reinstatement date will be considered a Pre-Existing Condition.]

This limitation will apply until coverage has been in force for [12-24] months after the reinstatement date. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.]

In all other respects, You and Our Company will have the same rights as existed under this policy before the coverage lapsed, subject to any provisions included with or attached to this policy in connection with the reinstatement.

VII. RECOVERY PROVISIONS

Overpayment

If a benefit is paid under this policy and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You or Your estate/Beneficiary. We may offset the overpayment against future benefit payments.

[Subrogation Right]

Subrogation is the process by which We seek reimbursement from another person or entity for a claim We have already paid. When benefits are paid on Your behalf under this policy, We are subrogated to all rights of recovery You have against any person, entity or other insurance coverage. This includes, but is not limited to, recoveries against:

- [1.] [A third party.]
- [2.] [Any liability coverage for a third party.]
- [3.] [Other insurance that You have, including uninsured or underinsured motorist coverage.]

This subrogation right extends to the proceeds of any settlement or judgment but is limited to the amount of benefits We have paid.

You must:

- 1. Do nothing to prejudice or hinder any right of recovery; and
- 2. Execute and deliver any instruments and papers that may be required by Us; and
- 3. Cooperate with Us to assist Us in securing Our subrogation rights.

If You bring a lawsuit or other proceeding to recover damages in connection with a disability resulting in loss of income for which We have paid benefits under this plan, You or Your attorney must provide Us with copies of all pleadings, notices and other documents and papers that are related to Our subrogation right under this plan. We reserve the right to intervene in any proceeding in which You are a party to the extent that such intervention is reasonably necessary to protect or execute Our subrogation right.

Upon recovery of any portion of Our subrogation interest by way of settlement or judgment, We will not be required, under any circumstances, to pay a fee to Your attorney or share in any costs incurred by You and/or Your attorney in bringing about the settlement or judgment. If We engage an attorney or other agent for the purpose of enforcing Our subrogation right, We will be entitled to an award of Our costs including, without limitation, reasonable attorneys' fees associated with all trial and appellate proceedings.

You are not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this plan.

If We are precluded from exercising Our subrogation right, We may exercise Our Right to Reimbursement provision in this plan.]

[Right to Reimbursement

When We pay benefits under this plan, We have the right to recover an amount equal to the amount We paid if You:

1. Seek recourse against any person, entity or other insurance coverage by suit, settlement, judgment or otherwise; and
2. Recover payment, in whole or in part, from any person, entity or other insurance coverage for the benefits that We previously paid under this plan.

This right to reimbursement extends to the proceeds of any settlement or judgment. This includes, but is not limited to, recoveries against:

- [1.] [A third party.]
- [2.] [Any liability coverage for a third party.]
- [3.] [Other insurance that You have, including uninsured or underinsured motorist coverage.]]

Reimbursement to Us will not exceed either the amount of benefits that We paid under this plan that You recovered from any other person, entity or other insurance coverage or the amount recovered from any other person, entity or other insurance coverage as payment for the same loss of income, whichever is less.

You must reimburse Us for any payments that We make prior to a determination as to whether a disability is work-related at the time that You receive payment for the loss of income from another source. You must agree to:

1. Notify Us of any workers' compensation claim that You make; and
2. Reimburse Us even when workers' compensation benefits are provided by means of a settlement or compromise.
3. Cooperate with Us to assist Us in securing Our right to reimbursement.

You must provide Us with timely written notification in the event that You suffer a disability in which a third party might be responsible and You seek recourse against any person, entity or other insurance coverage by suit, settlement, judgment or otherwise.

Such a notice must inform Us of:

1. The nature of the disability; and

2. The names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages or loss suffered by You; and
3. A description of the Accident or occurrence that You reasonably believe was responsible for the disability at issue and the approximate date(s) upon which such Accident or occurrence happened; and
4. The name of any legal counsel retained by You in connection with any such Accident or occurrence.

If You bring a lawsuit or other proceeding to recover damages in connection with any such Accident or occurrence, You or Your attorney must provide Us with copies of all pleadings, notices and other documents and papers that are related to Our right to reimbursement under this plan. We reserve the right to intervene in any proceeding in which You are a party to the extent that such intervention is reasonably necessary to protect or execute Our right to reimbursement under this plan.

Upon recovery of any portion of Our right to reimbursement interest by way of settlement or judgment, We will not be required, under any circumstances, to pay a fee to Your attorney or share in any costs incurred by You and/or Your attorney in bringing about the settlement or judgment. If We engage an attorney or other agent for the purpose of enforcing Our right to reimbursement, We will be entitled to an award of Our costs including, without limitation, reasonable attorneys' fees associated with all trial and appellate proceedings.

You are not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this plan.]

[Workers' Compensation Not Affected

Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.]

VIII. OTHER PROVISIONS

Policy Changes

No change in the policy will be valid unless approved by one of Our executive officers and included with this policy. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable application or application requirements.

Modification of Your Coverage

We may modify the insurance coverage for You under this policy at any time. This modification will be consistent with state law and will apply uniformly to all policies with Your plan of coverage. You will be notified of any change.

Clerical Error

If a clerical error is made by Us, it will not affect the insurance to which a Policyholder is entitled.

Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this policy.

The premium charges will be adjusted as required, but not for more than two years prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within 60 days of Our notifying You of the error.

[Change of Occupation

If the Policyholder changes his or her occupation to one classified by Us as more or less hazardous than that stated [in this policy][on the application], We, upon receipt of proof of change of occupation, may reduce or increase the premium rate accordingly, from the date we receive proof of change of occupation. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by Us prior to the date of proof of change in occupation with the state official having supervision of insurance in the state where the Policyholder resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by Us in such state prior to the date of proof of change in occupation.]

Conformity with Statutes

If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary. If payment of the benefits under this plan would violate any U.S. economic or trade sanctions, such coverage will be null and void.

Enforcement of Plan Provisions

Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

Entire Contract

This policy is issued to the Policyholder. The entire contract of insurance includes the policy, the benefit schedule, the Policyholder's application/application form, and any riders and endorsements to this plan.

[Incentives, Rebates and Contributions

We may elect to furnish or participate in programs with other organizations that furnish individual applicants for coverage or Policyholders that meet common criteria or requirements determined by Us with "premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted or where other gifts or items of value may be offered or provided to You at no charge or a discount at a time or times or for a period determined by Us.]

Misstatements

If a Policyholder's material information, including but not limited to occupation, age or income, has been misstated and the premium or benefit amount would have been different had the correct information been disclosed, an adjustment in premiums or benefit level will be made based on the corrected information. In addition to adjusting future premiums, We will require payment of past premiums at the adjusted rate to continue coverage. If the Policyholder's age or occupation is misstated and coverage would not have been issued based on the Policyholder's true age or occupation, Our sole liability will be to refund all of the premiums paid for that Policyholder's coverage, minus the amount of any benefits paid by Us.

[Representations Made on Application

A copy of the application form will be included when the policy is issued. All statements made on the application form will be deemed representations and not warranties. No statement made in the application form will be used in any suit or action at law or equity unless a copy of the application form is furnished to the Policyholder, or in the event of death or incapacity of the Policyholder, a copy will be furnished to the Policyholder's beneficiary or personal representative.]

Rescission of Insurance and/or Denial of Claim and Time Limit on Certain Defenses

Within the first three years after the Effective Date of coverage, We have the right to rescind or modify Your policy of insurance coverage and/or deny a claim for a Policyholder if the application form contains an omission or misrepresentation, whether intended or not, which We determine to be material. After three years from the Effective Date of this Policy, no misstatements, except fraudulent misstatements or omissions, made by the applicant in the applications/enrollment form for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such three-year period.

Legal Action

No suit or action at law or in equity may be brought to recover benefits under this plan until the expiration of 60 days after Proof of Loss has been furnished in accordance with the requirements of this Policy. You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review

process. No suit or action at law or in equity can be brought later than 3 years from the date proof of loss was required.

Forum

Any lawsuits or disputes arising under the terms of the Policy must be brought in the United States District Court for the Eastern District of Wisconsin.

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

SHORT TERM DISABILITY INCOME INSURANCE POLICY

The insurance described in this Policy is effective on the date shown in the Benefit Schedule only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan.

This policy describes the benefits and major provisions which affect the Policyholder. The Policy is issued in the State of [Arkansas] and is governed by applicable laws of that State and federal laws, except as otherwise provided by this Policy.

This policy is issued based on the statements and agreements in the application form, any exam that may be required, any other amendments or supplements and the payment of the required premium. This policy and premium cost may be changed. [If that happens, You will be notified of any such changes].

Please read Your policy carefully and become familiar with its terms, limits and conditions.

RIGHT TO EXAMINE POLICY FOR [10-30] DAYS

If You are not satisfied, return the policy to Us or Our agent within [10-30] days after You have received it. All premiums will be refunded and Your coverage will be void.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION FORM FOR INSURANCE

Please read the copy of the application form included with this policy. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the application form. If a material omission or misstatement is made in the application form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount. Carefully check the application form and, if any information shown in the application form is not correct and complete, write to Us at the address above, within [10-30] days.

[insert secretary signature]
Secretary

[insert president signature]
President

[This policy is guaranteed renewable until age [65-75] years.] [This policy contains a Pre-Existing Conditions Limitation.]

NOTICE: This policy insures for loss of income of the Policyholder when employed on a Full-Time Basis. This plan does not pay benefits when income [from Your Primary Occupation] does not exist prior to the date of disability[, except as provided by the Not-At-Work Disability Benefit]. Read Your policy carefully.

GUIDE TO YOUR POLICY

The sections of the policy appear in the following order:

- I. Definitions
- II. Effective Date and Termination Date
- III. Benefits
- IV. Exclusions and Limitations
- V. Claim Provisions
- VI. Premium Provisions
- VII. Recovery Provisions
- VIII. Other Provisions

I. DEFINITIONS

When reading this policy, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this policy are defined below. Just because a term is defined does not mean it is covered. Please read the policy carefully.

Accident or Accidental

Any unexpected event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.
2. It results from a trauma.
3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.
4. It is definite as to time and place.
5. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness or a cerebrovascular accident. Accident does not include any overdose of controlled substance, drug, or narcotic except when taken under the medical advice of a Health Care Practitioner.

Base Wages

The basic gross wage or salary paid as compensation to You for work performed on a Full-Time Basis, but not including overtime pay, bonuses, commissions, or any other special compensation not received as basic wages or salary. [If You are paid on an hourly basis, Base Wages will be based on the hourly rate of pay. No more than [40] hours per week will be considered in determining Base Wages for hourly workers.] Base Wages for self-employed individuals will be calculated by subtracting allowable business deduction amounts from the business's gross income.

Calendar Year

The period beginning on January 1 of any year and ending on December 31 of the same year.

Complications of Pregnancy

Complications of Pregnancy include the following:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, severe preeclampsia and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. Non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Cosmetic Services

A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or relieve or prevent social, emotional or psychological distress.

Effective Date

The date coverage under this plan begins for a Policyholder as stated on the Benefit Schedule. The Policyholder's coverage begins at 12:01 a.m. local time at the Policyholder's state of residence.

Eligible Disability Period

Eligible Disability Period means each separate period of Total [or Partial] Disability. However, a later period of Total [or Partial] Disability will be considered to be a continuation of the earlier "Eligible Disability Period" if it starts while the Policyholder is insured under this coverage and,

1. if the later period of Total [or Partial] Disability is due to the same or related causes as the earlier period of Total [or Partial] Disability, and it is separated by a return to work on a Full-Time Basis for less than [10-360][business days][calendar days], or
2. if the later period of Total [or Partial] Disability is due to causes not related to the earlier period of Total [or Partial] Disability, and it is separated by a return to work on a Full-Time Basis for less than [1-90][business day[s]][calendar day[s]].

The applicable Elimination Period and the Maximum Benefit Period shown on the Benefit Schedule apply to each Eligible Disability Period separately.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90][calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]

Elimination Period

The period of consecutive days that must pass after the beginning of a period of Total [or Partial] Disability before a Policyholder is eligible for specific benefits as shown in the Benefit Schedule under the terms of this plan. No benefits are payable during the Elimination Period. The Elimination Period applies separately to each Maximum Benefit Period.

An Elimination Period will vary depending on if the Total [or Partial] Disability is due to a [Non-Work Related] Sickness or Injury [or pregnancy or childbirth]. The Benefit Schedule will identify the applicable Elimination Periods.

Full-Time Basis

Working or scheduled to work at a job at least [30-40] hours per week for at least [35-50] weeks per Calendar Year for Base Wages.

Health Care Practitioner

A person licensed by the state or other geographic area in which the medical services are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

Home Office

Our office in [Milwaukee, Wisconsin] or other administrative offices as indicated by Us.

Immediate Family Member

An Immediate Family Member is:

1. You or Your spouse or
2. The children, brothers, sisters and parents of either You or Your spouse; or
3. The spouses of the children, brothers and sisters of You and Your spouse or
4. Anyone with whom a Policyholder has a relationship based on a legal guardianship.

Injury

Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

Maximum Benefit Period

The maximum time period per Eligible Disability Period for which benefits under this policy are payable following the applicable Elimination Period. [The Maximum Benefit Period is different depending on if the Total [or Partial] Disability is caused by [Non-Work Related Sickness or Injury] [Sickness, Injury,] [or] [pregnancy, or childbirth.] The applicable Maximum Benefit Period is stated on Your Benefit Schedule.

Medically Necessary or Medical Necessity

Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Policyholder's Immediate Family Member. We must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and
2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and
3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and
4. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.

Monthly Benefit

The amount of Monthly Benefit as shown on Your Benefit Schedule.

[Non-Work Related Sickness or Injury

Accidental Injury or Sickness occurring independent of any employment related activity.]

Partial Disability or Partially Disabled

As a result of the [Sickness or Injury][pregnancy or childbirth][Non-Work Related Sickness or Injury] that caused disability and for which You are under the care of a Health Care Practitioner, Your Primary Occupation Base Wages, that were effective on the day prior to Your becoming disabled, are reduced by up to [0-100%], and You are able to:

1. perform one or more, but not all, of the material and substantial duties of Your Primary Occupation on a Full-Time Basis; or
2. perform all of the material and substantial duties of Your Primary Occupation on a part-time basis.

Policyholder

The person to whom the policy is issued as shown in the Benefit Schedule.

Pre-Existing Condition

A Sickness or an Injury and related complications:

1. For which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed during the [6-24]-month period immediately prior to the Policyholder's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
2. That produced signs or symptoms during the [6-24]-month period immediately prior to the Policyholder's Effective Date.

The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

- a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
- b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

[A pregnancy that exists [on the day before][at anytime during the [6-24] month period prior to] the Policyholder's Effective Date will be considered a Pre-Existing Condition.]

Primary Occupation

Your Primary Occupation is the employment activity You engage in on a Full-Time Basis. In the event You are concurrently engaged in a more than one employment activity on a Full-Time Basis, Your Primary Occupation will be considered the employment providing the highest Base Wages.

Recurrent Disability

A period of Total [or Partial] Disability occurring at least [30-90] [calendar][business] days after the termination of a previous period of Total [or Partial] Disability which was a covered Eligible Disability Period under this policy and is not considered a continuation of that prior Eligible Disability Period as defined in this policy.

Sickness

A disease or illness of a Policyholder. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness. Sickness includes Complications of Pregnancy[, but not the pregnancy itself].]

Single Plan

A plan of insurance covering only the Policyholder.

[Special Exception Rider

A form that is included with this plan which identifies a body part, system, disease, Sickness, Injury or other condition for a Policyholder in which all charges related to that body part, system, disease, Sickness, Injury or other condition are excluded from coverage for a specified period of time as shown in the Special Exception Rider.]

Total Disability/Totally Disabled

You are unable to perform the essential duties of Your Primary Occupation resulting in [total loss of Base Wages income][a reduction of [50-100]% [or more] of Your Base Wages][, due to disability caused by [Sickness or Injury][Non-Work Related Sickness or Injury][[Sickness, Injury,] or pregnancy or childbirth] for which You are under the care of a Health Care Practitioner]. [Retired individuals and homemakers will not be considered unable to perform an occupation solely because they are unemployed.]

We, Us, Our, Our Company

Time Insurance Company or its administrator.

[Work Related Sickness or Injury

Accidental Injury or Sickness occurring during or arising out of any employment activity.]

You, Your, Yours

The person listed on the Benefit Schedule as the Policyholder.

II. EFFECTIVE DATE AND TERMINATION DATE

Eligibility and Effective Date of Policyholder

A person who is eligible may elect to be covered under this plan by completing and signing an application form and submitting any required premium. [You must be a resident of or employed in Your Primary Occupation in the state where this policy is issued on the Effective Date.]

Evidence of insurability must also be provided. Your coverage will take effect at 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

[This is a Single Plan only.]

[The rates may change for reasons including but not limited to if the Policyholder moves to another zip code or there is a change in benefits or class.]

Termination Date of Coverage

The Policyholder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid in accordance with the laws of the state in which the policy is issued minus any claims that were incurred after the termination date and paid by Us.

This policy will terminate at 12:01 a.m. local time in the state of issue on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this policy or on a later date that is requested by the Policyholder for termination
2. The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
3. The date of death of the Policyholder.
4. [The date there is fraud made by or with the knowledge of any Policyholder filing a claim for benefits.]

[5.] [The date the Policyholder moves to a state where We do not provide insurance coverage.]

[6.] [The date the Policyholder attains age [65-75] years.][The anniversary date of this policy following the Policyholder's [65th – 75th] birthday.]

III. SHORT TERM DISABILITY INCOME INSURANCE BENEFITS

WE WILL PAY BENEFITS ONLY AS PROVIDED IN THIS POLICY, INCLUDING THE BENEFIT SCHEDULE AND ANY RIDERS OR ENDORSEMENTS HERETO. THE MAXIMUM BENEFIT LIMITATION IS SHOWN ON THE BENEFIT SCHEDULE.

REFER TO THE EXCLUSIONS AND LIMITATIONS SECTION OF THE POLICY FOR DISABILITY THAT IS NOT COVERED UNDER THIS POLICY.

We will not pay benefits for disability during a Policyholder's Elimination Period as shown in the Benefit Schedule.

If the Policyholder, while insured under this policy subject to the Effective Date and Termination Date section of this policy, becomes continuously Totally [or Partially] Disabled as a result of [Non-Work Related Sickness or Injury][Injury][.][or] [Sickness] [or pregnancy or childbirth], We will pay Short Term Disability Income Insurance Benefits subject to the provisions below, Exclusions and Limitations provisions and all the terms and conditions of this policy.

Benefits are payable for only one Eligible Disability Period at a time, even if Total [or Partial] Disability is caused by concurrent [Non-Work Related Sickness or Injury] [Sickness or Injury][.][or pregnancy or childbirth]. If You have other short term disability income coverage under another plan with Us or one of Our affiliated companies, We will pay only the plan benefits providing the greatest [total] benefit amount per eligible disability.

Total Disability Benefits

The Monthly Benefit will be paid for an Eligible Disability Period due to the Total Disability from the first day of the Eligible Disability Period following the applicable Elimination Period, as shown on the Benefit Schedule, until the Maximum Benefit Period has been attained or You are no longer Totally Disabled, if earlier. When the Eligible Disability Period occurs during only a portion of a calendar month, the Monthly Benefit due for that period will be prorated according to the days of Total Disability during the Eligible Disability Period occurring that month.

Total Disability Benefits are not payable for any time during the Eligible Disability Period during which You are receiving any wages or compensation for any work, regardless of whether or not it is Your Primary Occupation.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]

[Partial Disability Benefits

A portion of the Monthly Benefit will be paid for an Eligible Disability Period due to Partial Disability from the first day of the Eligible Disability Period following the applicable Elimination Period, as shown on the Benefit Schedule, until the Maximum Benefit Period has been attained. The available benefit would be payable as a percentage of the Monthly Benefit equal to the

percentage of wage loss resulting from the Partial Disability, not to exceed [0-100%] of the Monthly Benefit.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]]

[Disability Benefits Related to Pregnancy or Childbirth

We will pay benefits under this policy for Total [or Partial] Disability that is related to or caused by pregnancy or childbirth, including complications, only when such Disability commences after the first [10-24] months from the Effective Date. Benefits are limited by the Maximum Benefit Period specifically for pregnancy or childbirth as stated on the Benefit Schedule.] [A condition that has been specifically excluded from coverage will continue to be excluded after [10-24] months of continuous coverage.]]

[Waiver of Premium

[This Waiver of Premium provision becomes effective only after You have been continuously insured under this policy for [[15-365] days][[2-18] months]. [After such waiting period, i][l]n the event You are continuously Totally [or Partially] Disabled for at least 90 calendar days, We will waive [monthly] premium payments due for the remainder of the current Eligible Disability Period up to the Maximum Benefit Period. When Waiver of Premium benefit is being provided, You are required to provide a monthly Health Care Practitioner's statement documenting Your continued Total [or Partial] Disability. Under no circumstances will Waiver of Premium extend beyond the period during which You are Totally [or Partially] Disabled. [We will not waive premium for any disability related to pregnancy or childbirth regardless of the duration of the disability.] [The Waiver of Premium benefit is only available during the course of one Eligible Disability Period every [3-5] years.]]

IV. EXCLUSIONS AND LIMITATIONS

[Pre-Existing Conditions Limitation

We will not pay benefits under this policy for Total [or Partial] Disability that is related to or caused by a Pre-Existing Condition until the Policyholder has been continuously covered under this policy for [12-24] months. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.] [A pregnancy that exists [on the day before][at any time during the [6-24]month period prior to] the Policyholder's Effective Date will be considered a Pre-Existing Condition.]]

[Sickness Limitation on New Policy

We will not pay benefits under this policy for Total [or Partial] Disability that is related to or caused by a Sickness that manifests itself or is diagnosed or treated within the first 30 days from the Effective Date until the Policyholder has been continuously covered under this policy for [12-24] months. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.]]

General Exclusions

We will not pay benefits for Total Disability [or Partial Disability] caused, whether in whole or in part, by any of the following:

1. disability for which Our liability cannot be determined because a Policyholder, Health Care Practitioner, facility, or other individual or entity within 30 calendar days of Our request, failed to:
 - a. Authorize the release of all medical records to Us and other information We requested.
 - b. Provide Us with information We requested about pending claims or other insurance coverage.
 - c. Provide Us with information as required by any contract with Us.
 - d. Provide Us with information that is accurate and complete.
 - e. Have any examination completed as We requested.
 - f. Provide reasonable cooperation to any requests made by Us

Upon receipt of information allowing the determination of Our liability, We will reopen any claim for benefits. No claim for benefits can be reopened after [180-540] [calendar][business] days.

- [2.] [disability that is related to or a complication of a Pre-Existing Condition.]
- [3.] [disability caused by [Work-Related] Sickness or Injury[eligible for benefits under worker's compensation, employers' liability or similar laws even when the Policyholder does not file a claim for benefits]. [This exclusion will not apply to any of the following:
 - [a.] [The sole proprietor, if the Policyholder's employer is a proprietorship.]
 - [b.] [A partner of the Policyholder's employer, if the employer is a partnership.]

- [c.] [An executive officer of the Policyholder's employer, if the Policyholder's employer is a corporation.]
- [d.] [A Policyholder who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.]]]
- [4.] [disability for which a Policyholder is entitled to loss of income benefits under any motor vehicle medical payment or premises medical expense coverage. Coverage under this policy is secondary to disability income payment or coverage available to the Policyholder, regardless of whether such other coverage is described as secondary, excess or contingent.]
- [5.] [disability caused by or contributed to by:
 - a. War or any act of war, whether declared or undeclared.
 - b. Participation in the military service of any country or international organization, including non-military units supporting such forces.
 - c. Foreign or domestic acts of terrorism[that result in a nationwide epidemic].]
- [6.] [disability caused by or related to the Policyholder's weight or related to obesity or morbid obesity conditions, including treatment thereof.]
- [7.] [disability caused by or related to maternity, pregnancy, or childbirth[when the disability begins less than [270-365] calendar days from the Effective Date or date of reinstatement], except for Complications of Pregnancy.]
- [8.] [disability caused by or related to the following, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual function, and treatments thereof.]
- [9.] [disability caused by or related to treatment, services, supplies or drugs designed or used to diagnose, treat, alter, impact, or differentiate a Policyholder's genetic make-up or genetic predisposition.]
- [10.] [disability caused by or related to: [mental illness; anxiety or nervous disorders;] [being intoxicated or under the influence of any controlled substance, except when taken under the medical advice of a Health Care Practitioner;] [behavior modification or behavioral (conduct) problems;] or [learning disabilities]. [Mental illness and anxiety or nervous disorders include all disorders listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.]]
- [11.] [disability caused by or related to an Injury sustained in operating a motor vehicle while the Policyholder is intoxicated and, as defined by law, the Policyholder's blood alcohol level was over the legal limit. This exclusion applies whether or not the Policyholder is charged with any violation in connection with the Accident.]

- [12.] [disability caused by or related to Sickness or Injury of which a contributing cause was the Policyholder's voluntary attempt to commit, participation in or commission of a felony, misdemeanor, or illegal act.]
- [13.] any amount in excess of the Maximum Benefit Period or any other maximum benefit for covered benefits.
- [14.] disability caused by or related to Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, including voluntary ingestion, inhalation or injection of poisons, toxins or gaseous substances, even if the Policyholder did not intend to cause the harm which resulted from the action. This exclusion applies regardless of whether the Policyholder was sane or insane at the time the event occurred.
- [15.] [disability caused by or related to Injury received while engaging in any hazardous occupation or other activity including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [horse riding] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]
- [16.] [disability caused by or related to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [skiing], [horse riding] [, hunting] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]
- [17.] disability caused by or related to chemical peels, reconstructive or cosmetic/plastic surgery that does not alleviate a functional impairment, and other Cosmetic Services.
- [18.] [disability occurring or being treated outside of the United States [or Canada].]
- [19.] disability caused by or related to flight in an aircraft other than as a fare-paying passenger on a regularly scheduled flight by an airline.
- [20.] disability caused by or related to any organ donation[, within the first 12 months following the Effective Date], sterilization or any other [elective] procedure that is not Medically Necessary.

[21.][disability caused by or related to any condition, treatment, body part, or system specifically excluded by a Special Exception Rider.]

[22.] [disability caused by or contributed by a complication of a Sickness, Injury, or medical treatment or services that are not covered under this policy.]

V. CLAIM PROVISIONS

Notice of Claim

You must notify Us of the claim within [20-90] [calendar][business] days after the start of an Eligible Disability Period, or as soon as reasonably possible[, by calling Our Home Office]. When providing notice of claim, You must include Your name, address, and policy number. .

Claim Forms

Within [15-30] [calendar][business] days after We receive Your notice of claim, We will provide claim forms to be used when submitting Proof of Loss. The forms must be completed and sent to Us or Our designee. If You do not receive the claim forms within [15-30] [calendar][business] days, we will accept a written description of the exact nature and extent of the loss as Proof of Loss provided it meets the requirements, including timeframes, for submitting Proof of Loss stated below.

Proof of Loss

We must receive written or electronic proof of loss for Total [or Partial] Disability due to a [Non-Work Related]Sickness or an Injury [or pregnancy or childbirth]for which the claim is made. Proof of loss must be provided to Us within [90-180] calendar days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date the [Eligible Disability Period or Maximum Benefit Period ends, whichever is later,][Proof of Loss is otherwise required,] unless You are declared incompetent by a court of law.

The proof of loss must include all of the following:

- 1) Your name, address and policy number.
- 2) Verification of Your income and occupation.
- 3) The details and supporting medical documentation of the loss for which claim is made.

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us.

Right to Collect Information

To determine Our liability, We may request additional information from a Policyholder, Health Care Practitioner, facility, or other individual or entity. A Policyholder must cooperate with Us, and assist Us by obtaining the following information within [30-90][calendar][business] days of Our request. Benefits will be denied if We are unable to determine Our liability because a Policyholder, Health Care Practitioner, facility, or other individual or entity failed to:

1. Authorize the release of all medical records to Us and other information We requested.
2. Provide Us with information We requested about pending claims or other insurance coverage.
3. Provide Us with information as required by any contract with Us.
4. Provide Us with information that is accurate and complete.

5. Have any examination completed as requested by Us.
6. Provide reasonable cooperation to any requests made by Us.

Upon receipt of information allowing the determination of Our liability, We will reopen any claim for benefits. No claim for benefits can be reopened after [180-540] [calendar][business] days.

Physical Examination Medical Review and Autopsy

We have the right to have a Health Care Practitioner of Our choice conduct a review of medical records and/or examine a Policyholder at any time regarding a claim for benefits or to verify any claim of Total [or Partial] Disability. Health Care Practitioner charges for these reviews and/or exams will be paid by Us. We also have the right, in case of death, to have an autopsy done, at Our expense, where it is not prohibited by law.

Payment of Benefits

When We receive due written proof of the disability and determine Our liability, benefits will be paid to the Policyholder [once a week][every 2 weeks][at least once per month], but will be determined by the actual number of calendar days You are Totally Disabled [or Partially Disabled] in accordance with the Short Term Disability Income Insurance Benefits section. Any benefits unpaid at Your death will be paid at Our option to Your spouse, Your estate or the providers of the services. Benefits may not be assigned.

Any amount We pay will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for coverage of a Sickness or an Injury. It also does not constitute any assumption of liability for further coverage. Any benefit paid in error may be recovered from You or the person or entity receiving the incorrect payment. We may offset the overpayment against future benefit payments.

Rights of Administration

We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.

Claims Involving Fraud or Misrepresentation

Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Policyholder or a Policyholder's representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved fraud or misrepresentation, We will be entitled to a refund from You, the Beneficiary or the person receiving the payment.

If the Policyholder, or anyone acting on the Policyholder's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Policyholder may be subject to civil and/or criminal penalties.

Claim Appeal

You have the right to request a review of all adverse claim decisions. A review must be requested by writing to Us at Our Home Office within 180 [calendar][business] days following Your receipt of the notice that the claim was denied or reduced.

VI. PREMIUM PROVISIONS

Consideration

This plan is issued based on the statements and agreements in the Policyholder's application form, any exam of a Policyholder that is required, any other amendment or supplements to the application form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

Premium Payment

The initial premium must be paid [on or before the Effective Date for this coverage to be in force. Subsequent premiums are due] as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received [by] [Us][or][Our designee][in cash or check][or][by credit card or automatic charge to a bank account][at Our office] on [or before] the date due. [We may agree to accept premium payment in alternative forms[, such as credit card or automatic charge to a bank account].] If We tried to obtain payment for the amount due but were unsuccessful, We reserve the right to require an alternative form of payment during the grace period.

[Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] age, plan design, [smoking status,] and change in occupation. All premium adjustments will be made to individuals on the basis of shared characteristics. The mode of payment (monthly, quarterly or other) is subject to change, You will be notified at least 60 days in advance of any such change.]

Grace Period

There is a grace period of 31 calendar days for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the grace period ends.

Coverage will continue during the grace period unless You call Our office or give Us written notice to cancel the coverage. If a claim is payable during the grace period, any unpaid premiums due will be deducted from the claim payment.

[Suspension of Premium

If[, after the Effective Date,] You cease to be employed[on a Full-Time Basis][, due to [involuntary][or][voluntary]loss of employment,] We will suspend Your premium payments for the period of time You are not employed[on a Full-Time Basis], up to [60-365] calendar days. You must notify Us, in writing [or by calling Our Home Office,] when You cease working on a Full-Time Basis in order to suspend Your premium payments. Benefits are not payable during the period that You are not working on a Full-Time Basis. You must notify Us, in writing [or by calling Our Home Office,] when you resume employment on a Full-Time Basis to have Your coverage reinstated.]

Reinstatement

If any premium is not paid within the required time period, coverage for You will lapse. The coverage will be reinstated if all of the following requirements are met:

1. The lapse was not more than [30-365] calendar days.
2. You submit a supplemental application form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us.
3. We approve Your application form for reinstatement.

The coverage will be reinstated on the date We approve Your application form for reinstatement, but no later than 45 days after receipt of the reinstatement application, unless We have provided written notice of disapproval to You.. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

If the coverage is reinstated, the policy is subject to a new Pre-Existing Condition period that begins on the date that We approve Your application form for reinstatement.

A reinstated policy will only cover loss resulting from a[n] [Non-Work Related]Injury if it is sustained after the date of reinstatement. Loss resulting from [Non-Work Related]Sickness [or pregnancy] will be covered only for disability commencing after 10 days following the date of reinstatement. No benefits will be paid for any such condition and related complications if prior to the reinstatement date:

1. Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed regardless of whether the condition was diagnosed or not diagnosed; or
2. The condition produced signs or symptoms that were significant enough to establish manifestation or onset by one of the following tests:
 - a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
 - b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

[A pregnancy that exists on the day before the reinstatement date will be considered a Pre-Existing Condition.]

This limitation will apply until coverage has been in force for [12-24] months after the reinstatement date. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.]

In all other respects, You and Our Company will have the same rights as existed under this policy before the coverage lapsed, subject to any provisions included with or attached to this policy in connection with the reinstatement.

VII. RECOVERY PROVISIONS

Overpayment

If a benefit is paid under this policy and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You or Your estate/Beneficiary. We may offset the overpayment against future benefit payments.

[Subrogation Right]

Subrogation is the process by which We seek reimbursement from another person or entity for a claim We have already paid. When benefits are paid on Your behalf under this policy, We are subrogated to all rights of recovery You have against any person, entity or other insurance coverage. This includes, but is not limited to, recoveries against:

- [1.] [A third party.]
- [2.] [Any liability coverage for a third party.]
- [3.] [Other insurance that You have, including uninsured or underinsured motorist coverage.]

This subrogation right extends to the proceeds of any settlement or judgment but is limited to the amount of benefits We have paid.

You must:

- 1. Do nothing to prejudice or hinder any right of recovery; and
- 2. Execute and deliver any instruments and papers that may be required by Us; and
- 3. Cooperate with Us to assist Us in securing Our subrogation rights.

If You bring a lawsuit or other proceeding to recover damages in connection with a disability resulting in loss of income for which We have paid benefits under this plan, You or Your attorney must provide Us with copies of all pleadings, notices and other documents and papers that are related to Our subrogation right under this plan. We reserve the right to intervene in any proceeding in which You are a party to the extent that such intervention is reasonably necessary to protect or execute Our subrogation right.

Upon recovery of any portion of Our subrogation interest by way of settlement or judgment, We will not be required, under any circumstances, to pay a fee to Your attorney or share in any costs incurred by You and/or Your attorney in bringing about the settlement or judgment. If We engage an attorney or other agent for the purpose of enforcing Our subrogation right, We will be entitled to an award of Our costs including, without limitation, reasonable attorneys' fees associated with all trial and appellate proceedings.

You are not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this plan.

If We are precluded from exercising Our subrogation right, We may exercise Our Right to Reimbursement provision in this plan.]

[Right to Reimbursement

When We pay benefits under this plan, We have the right to recover an amount equal to the amount We paid if You:

1. Seek recourse against any person, entity or other insurance coverage by suit, settlement, judgment or otherwise; and
2. Recover payment, in whole or in part, from any person, entity or other insurance coverage for the benefits that We previously paid under this plan.

This right to reimbursement extends to the proceeds of any settlement or judgment. This includes, but is not limited to, recoveries against:

- [1.] [A third party.]
- [2.] [Any liability coverage for a third party.]
- [3.] [Other insurance that You have, including uninsured or underinsured motorist coverage.]]

Reimbursement to Us will not exceed either the amount of benefits that We paid under this plan that You recovered from any other person, entity or other insurance coverage or the amount recovered from any other person, entity or other insurance coverage as payment for the same loss of income, whichever is less.

You must reimburse Us for any payments that We make prior to a determination as to whether a disability is work-related at the time that You receive payment for the loss of income from another source. You must agree to:

1. Notify Us of any workers' compensation claim that You make; and
2. Reimburse Us even when workers' compensation benefits are provided by means of a settlement or compromise.
3. Cooperate with Us to assist Us in securing Our right to reimbursement.

You must provide Us with timely written notification in the event that You suffer a disability in which a third party might be responsible and You seek recourse against any person, entity or other insurance coverage by suit, settlement, judgment or otherwise.

Such a notice must inform Us of:

1. The nature of the disability; and

2. The names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages or loss suffered by You; and
3. A description of the Accident or occurrence that You reasonably believe was responsible for the disability at issue and the approximate date(s) upon which such Accident or occurrence happened; and
4. The name of any legal counsel retained by You in connection with any such Accident or occurrence.

If You bring a lawsuit or other proceeding to recover damages in connection with any such Accident or occurrence, You or Your attorney must provide Us with copies of all pleadings, notices and other documents and papers that are related to Our right to reimbursement under this plan. We reserve the right to intervene in any proceeding in which You are a party to the extent that such intervention is reasonably necessary to protect or execute Our right to reimbursement under this plan.

Upon recovery of any portion of Our right to reimbursement interest by way of settlement or judgment, We will not be required, under any circumstances, to pay a fee to Your attorney or share in any costs incurred by You and/or Your attorney in bringing about the settlement or judgment. If We engage an attorney or other agent for the purpose of enforcing Our right to reimbursement, We will be entitled to an award of Our costs including, without limitation, reasonable attorneys' fees associated with all trial and appellate proceedings.

You are not obligated by this provision to seek legal action against any person or entity for recovery of benefits paid under this plan.]

[Workers' Compensation Not Affected

Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.]

VIII. OTHER PROVISIONS

Policy Changes

No change in the policy will be valid unless approved by one of Our executive officers and included with this policy. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable application or application requirements.

Modification of Your Coverage

We may modify the insurance coverage for You under this policy at any time. This modification will be consistent with state law and will apply uniformly to all policies with Your plan of coverage. You will be notified of any change.

Clerical Error

If a clerical error is made by Us, it will not affect the insurance to which a Policyholder is entitled.

Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this policy.

The premium charges will be adjusted as required, but not for more than two years prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within 60 days of Our notifying You of the error.

[Change of Occupation

If the Policyholder changes his or her occupation to one classified by Us as more or less hazardous than that stated [in this policy][on the application], We, upon receipt of proof of change of occupation, may reduce or increase the premium rate accordingly, from the date we receive proof of change of occupation. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by Us prior to the date of proof of change in occupation with the state official having supervision of insurance in the state where the Policyholder resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by Us in such state prior to the date of proof of change in occupation.]

Conformity with Statutes

If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary. If payment of the benefits under this plan would violate any U.S. economic or trade sanctions, such coverage will be null and void.

Enforcement of Plan Provisions

Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

Entire Contract

This policy is issued to the Policyholder. The entire contract of insurance includes the policy, the benefit schedule, the Policyholder's application/application form, and any riders and endorsements to this plan.

[Incentives, Rebates and Contributions

We may elect to furnish or participate in programs with other organizations that furnish individual applicants for coverage or Policyholders that meet common criteria or requirements determined by Us with "premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted or where other gifts or items of value may be offered or provided to You at no charge or a discount at a time or times or for a period determined by Us.]

Misstatements

If a Policyholder's material information, including but not limited to occupation, age or income, has been misstated and the premium or benefit amount would have been different had the correct information been disclosed, an adjustment in premiums or benefit level will be made based on the corrected information. In addition to adjusting future premiums, We will require payment of past premiums at the adjusted rate to continue coverage. If the Policyholder's age or occupation is misstated and coverage would not have been issued based on the Policyholder's true age or occupation, Our sole liability will be to refund all of the premiums paid for that Policyholder's coverage, minus the amount of any benefits paid by Us.

[Representations Made on Application

A copy of the application form will be included when the policy is issued. All statements made on the application form will be deemed representations and not warranties. No statement made in the application form will be used in any suit or action at law or equity unless a copy of the application form is furnished to the Policyholder, or in the event of death or incapacity of the Policyholder, a copy will be furnished to the Policyholder's beneficiary or personal representative.]

Rescission of Insurance and/or Denial of Claim and Time Limit on Certain Defenses

Within the first three years after the Effective Date of coverage, We have the right to rescind or modify Your policy of insurance coverage and/or deny a claim for a Policyholder if the application form contains an omission or misrepresentation, whether intended or not, which We determine to be material. After three years from the Effective Date of this Policy, no misstatements, except fraudulent misstatements or omissions, made by the applicant in the applications/enrollment form for this Policy will be used to void the Policy or to deny a claim for loss incurred or disability commencing after the expiration of such three-year period.

Legal Action

No suit or action at law or in equity may be brought to recover benefits under this plan until the expiration of 60 days after Proof of Loss has been furnished in accordance with the requirements of this Policy. You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review

process. No suit or action at law or in equity can be brought later than 3 years from the date proof of loss was required.

Forum

Any lawsuits or disputes arising under the terms of the Policy must be brought in the United States District Court for the Eastern District of Wisconsin.

**SHORT TERM DISABILITY INCOME COVERAGE
OUTLINE OF COVERAGE FOR
POLICY FORM 8034.POL.AR**

THIS POLICY PROVIDES LIMITED BENEFITS

**BENEFITS PROVIDED ARE FOR LOSS OF INCOME AND
DO NOT PROVIDE REIMBURSEMENT OF MEDICAL EXPENSES**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of the policy. This is not the insurance policy and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and [Time Insurance Company]. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

SHORT TERM DISABILITY INCOME COVERAGE: Policies of this category are designed to provide, to the person insured, coverage for disability resulting from a covered injury or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

BENEFITS: The following provisions set forth the benefits which are covered under the policy subject to the conditions and exclusions and limitations set forth herein. The policy provides the policyholder with short term disability income insurance benefits if the policyholder becomes continuously Totally [or Partially] Disabled as a result of [Non-Work Related Sickness or Injury][Injury][,][or] [Sickness] [or pregnancy or childbirth]. Benefits are payable for only one eligible disability period at a time.

| [COVERAGE INFORMATION] |
|--|
| Monthly Benefit: [\$ _____] Elimination Period - Injury: [_____] days Elimination Period - Sickness: [_____] days Maximum Benefit Period: [[4-104] weeks][[30-730]days] per Eligible Disability Period for [Non-Work Related] Sickness or Injury. [[[4-52] weeks][[30-365] days] per Eligible Disability Period for pregnancy. [[4-52] weeks][[30-365] days] per Eligible Disability Period for childbirth. The Maximum Benefit Period for pregnancy or childbirth may be extended to the term of Maximum Benefit Period for [Non-Work Related] Sickness or Injury stated above if You provide proof of continued disability beyond the period for pregnancy or childbirth.] |
| [PREMIUM INFORMATION] |
| Premium Payment Mode: _____ TOTAL MODAL PREMIUM AMOUNT: _____]] |

BENEFITS PROVIDED BY THE POLICY:

Total Disability Benefits

The Monthly Benefit will be paid for an Eligible Disability Period due to the Total Disability from the first day of the Eligible Disability Period following the applicable Elimination Period, as shown on the Benefit Schedule, until the Maximum Benefit Period has been attained or You are no longer Totally Disabled, if earlier. When the Eligible Disability Period occurs during only a portion of a calendar month, the Monthly Benefit due for that period will be prorated according to the days of Total Disability during the Eligible Disability Period occurring that month.

Total Disability Benefits are not payable for any time during the Eligible Disability Period during which You are receiving any wages or compensation for any work, regardless of whether or not it is Your Primary Occupation.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]

[Partial Disability Benefits]

A portion of the Monthly Benefit will be paid for an Eligible Disability Period due to Partial Disability from the first day of the Eligible Disability Period following the applicable Elimination Period, as shown on the Benefit Schedule, until the Maximum Benefit Period has been attained. The available benefit would be payable as a percentage of the Monthly Benefit equal to the percentage of wage loss resulting from the Partial Disability, not to exceed [0-100%] of the Monthly Benefit.

[An Eligible Disability Period will only be considered for benefits under this policy after You have been actively at work on a Full-Time Basis for a continuous period of at least [30-90] [calendar][business] days immediately prior to the date of disability except for Recurrent Disability.]]

[Disability Benefits Related to Pregnancy or Childbirth]

We will pay benefits under this policy for Total [or Partial] Disability that is related to or caused by pregnancy or childbirth, including complications, only when such Disability commences after the first [10-24] months from the Effective Date. Benefits are limited by the Maximum Benefit Period specifically for pregnancy or childbirth as stated on the Benefit Schedule.] [A condition that has been specifically excluded from coverage will continue to be excluded after [10-24] months of continuous coverage.]]

[Waiver of Premium]

[This Waiver of Premium provision becomes effective only after You have been continuously insured under this policy for [[15-365] days][[2-18] months]. [After such waiting period, i]n the event You are continuously Totally [or Partially] Disabled for at least 90 calendar days, We will waive [monthly] premium payments due for the remainder of the current Eligible Disability Period up to the Maximum Benefit Period. When Waiver of Premium benefit is being provided, You are required to provide a monthly Health Care Practitioner's statement documenting Your continued Total [or Partial] Disability. Under no circumstances will Waiver of Premium extend beyond the period during which You are Totally [or Partially] Disabled. [We will not waive premium for any disability related to pregnancy or childbirth regardless of the duration of the disability.] [The Waiver of Premium benefit is only available during the course of one Eligible Disability Period every [3-5] years.]]

DEFINITIONS:

[Partial Disability or Partially Disabled]

As a result of the [Sickness or Injury][pregnancy or childbirth][Non-Work Related Sickness or Injury] that caused disability and for which You are under the care of a Health Care Practitioner, Your Primary Occupation Base Wages, that were effective on the day prior to Your becoming disabled, are reduced by up to [0-100%], and You are able to:

1. perform one or more, but not all, of the material and substantial duties of Your Primary Occupation on a Full-Time Basis; or
2. perform all of the material and substantial duties of Your Primary Occupation on a part-time basis.]]

Total Disability/Totally Disabled

You are unable to perform the essential duties of Your Primary Occupation resulting in [total loss of Base Wages income][a reduction of [50-100]% [or more] of Your Base Wages][, due to disability caused by [Sickness or Injury][Non-Work Related Sickness or Injury][[Sickness, Injury,] or pregnancy or childbirth] for which You are under the care of a Health Care Practitioner]. [Retired individuals and homemakers will not be considered unable to perform an occupation solely because they are unemployed.]

PRE-EXISTING CONDITIONS LIMITATION: Benefits will not be paid under the policy for Total [or Partial] Disability that is related to or caused by a Pre-Existing Condition until the Policyholder has been continuously covered under the policy for [12-24] months. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.] [A pregnancy that exists [on the day before][at any time during the [6-24]month period prior to] the Policyholder's Effective Date will be considered a Pre-Existing Condition.]]

EXCLUSIONS AND LIMITATIONS:

Benefits are not payable for losses caused or contributed to by:

1. disability for which Our liability cannot be determined because a Policyholder, Health Care Practitioner, facility, or other individual or entity within 30 days of Our request, failed to:
 - a. Authorize the release of all medical records to Us and other information We requested.
 - b. Provide Us with information We requested about pending claims or other insurance coverage.
 - c. Provide Us with information as required by any contract with Us.
 - d. Provide Us with information that is accurate and complete.
 - e. Have any examination completed as We requested.
 - f. Provide reasonable cooperation to any requests made by Us
- [2.] [disability that is related to or a complication of a Pre-Existing Condition.]
- [3.] [disability caused by [Work-Related] Sickness or Injury[eligible for benefits under worker's compensation, employers' liability or similar laws even when the Policyholder does not file a claim for benefits]. [This exclusion will not apply to any of the following:
 - [a.] [The sole proprietor, if the Policyholder's employer is a proprietorship.]
 - [b.] [A partner of the Policyholder's employer, if the employer is a partnership.]
 - [c.] [An executive officer of the Policyholder's employer, if the Policyholder's employer is a corporation.]
 - [d.] [A Policyholder who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.]]]
- [4.] [disability for which a Policyholder is entitled to loss of income benefits under any motor vehicle medical payment or premises medical expense coverage. Coverage under this policy is secondary to disability income payment or coverage available to the Policyholder, regardless of whether such other coverage is described as secondary, excess or contingent.]
- [5.] [disability caused by or contributed to by:
 - a. War or any act of war, whether declared or undeclared.
 - b. Participation in the military service of any country or international organization, including non-military units supporting such forces.
 - c. Foreign or domestic acts of terrorism[that result in a nationwide epidemic].]
- [6.] [disability caused by or related to the Policyholder's weight or related to obesity or morbid obesity conditions, including treatment thereof.]
- [7.] [disability caused by or related to maternity, pregnancy, or childbirth[when the disability begins less than [270-365] calendar days from the Effective Date or date of reinstatement], except for Complications of Pregnancy.]
- [8.] [disability caused by or related to the following, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual function, and treatments thereof.]
- [9.] [disability caused by or related to treatment, services, supplies or drugs designed or used to diagnose, treat, alter, impact, or differentiate a Policyholder's genetic make-up or genetic predisposition.]
- [10.] [disability caused by or related to: mental illness; anxiety or nervous disorders; being intoxicated or under the influence of any controlled substance, except when taken under the medical advice of a Health Care Practitioner; behavior modification or behavioral (conduct) problems; or learning disabilities. Mental illness and anxiety or nervous disorders include all disorders listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.]
- [11.] [disability caused by or related to an Injury sustained in operating a motor vehicle while the Policyholder is intoxicated and, as defined by law, the Policyholder's blood alcohol level was over the legal limit. This exclusion applies whether or not the Policyholder is charged with any violation in connection with the Accident.]
- [12.] [disability caused by or related to Sickness or Injury of which a contributing cause was the Policyholder's voluntary attempt to commit, participation in or commission of a felony,

misdemeanor, or illegal act.]

[13.] any amount in excess of the Maximum Benefit Period or any other maximum benefit for covered benefits.

[14.] disability caused by or related to Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, including voluntary ingestion, inhalation or injection of poisons, toxins or gaseous substances, even if the Policyholder did not intend to cause the harm which resulted from the action. This exclusion applies regardless of whether the Policyholder was sane or insane at the time the event occurred.

[15.] [disability caused by or related to Injury received while engaging in any hazardous occupation or other activity including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [horse riding] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]

[16.] [disability caused by or related to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [skiing], [horse riding] [, hunting] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]

[17.] disability caused by or related to chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment, and other Cosmetic Services.

[18.] [disability occurring or being treated outside of the United States [or Canada].]

[19.] disability caused by or related to flight in an aircraft other than as a fare-paying passenger on a regularly scheduled flight by an airline.

[20.] disability caused by or related to any organ donation[, within the first 12 months following the Effective Date], sterilization or any other [elective] procedure that is not Medically Necessary.

[21.] [disability caused by or related to any condition, treatment, body part, or system specifically excluded by a Special Exception Rider.]

[22.] [disability caused by or contributed by a complication of a Sickness, Injury, or medical treatment or services that are not covered under this policy.]

RENEWABILITY PROVISION: The policy will remain in force except for any one of the following reasons:

- The date We receive a request in writing or by telephone to terminate this policy on a later date that is requested by the Policyholder for termination
- The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
- The date of death of the Policyholder.
- [The date there is fraud made by or with the knowledge of any Policyholder filing a claim for benefits.]
- [The date the Policyholder moves to a state where We do not provide insurance coverage.]
- [The date the Policyholder attains age [65-75] years.][The anniversary date of this policy following the Policyholder's [65th – 75th] birthday.] [We may renew Your policy beyond this date if You provide Us with acceptable proof of continued employment beyond such date.]

PREMIUM: The first page shows the total premium for the coverage that was selected. [Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] age, plan design, [smoking status,] and change in occupation. All premium adjustments

will be made to individuals on the basis of shared characteristics. The mode of payment (monthly, quarterly or other) is subject to change, You will be notified at least 60 days in advance of any such change.]

[RIDERS]

[The following Rider[s] [is]/[are] available with Short Term Disability Income Policy 8034.POL.AR.]

Licensed Agent's Signature

Date